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ABSTRACT

The eighth volume in a 10-volume report on the historical development (1966-1973) of the 8 administrative Area Offices of the Indian Health Service (IHS) Mental Health Programs, this report presents information on the Phoenix Area Office and the Tucson Sub-Area Office. Included in this document are: (1) The Context: Political and Geographic (the Phoenix area as a whole, including states, offices, etc., and regional characteristics); (2) Centralized Development of Mental Health Programs in the Phoenix Area (1967-69 and the first mental health Area Chief and 1969-70 staff increases and program description); (3) 1970-72: Decentralization and the Introduction of Mental Health Technicians (professional staff changes, mental health technicians, excerpt of annual report for 1971, and training activities); (4) 1972-73: Consolidation (annual report, special consultant, and summary of policies and problems); (5) Service Unit Programs (Reno Field Office: Schurz Hospital and Stewart Indian School; Owyhee Service Unit, Duck Valley Reservation; Fort Duchesne, Utah; Hopi; White Mountain and San Carlos Apache; Pima-Maricopa Reservation, Sacaton, Arizona; Colorado River Tribes; and City of Phoenix); (6) Summary (problems and accomplishments); (7) Tucson Sub-Area (description of Papago Reservation, the Office of Research and Development, Desert Willow Training Center, Papago Health System, summary of problems and accomplishments). (JC)

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Vol. 2, Set 1

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PHOENIX AREA

Service Networks
and
Patterns of Utilization

Mental Health Programs I.I.S.

Partial fulfillment of
Contract No. 110-73-342

U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

PHOENIX AREA

MENTAL HEALTH PROGRAMS
OF THE
INDIAN HEALTH SERVICE
1966-1974

1975

IHS Contract No. IHS HSM 110-73-342

A documentary narrative in partial fulfillment of contract entitled:

Service Networks and Patterns of Utilization
Mental Health Programs
Indian Health Service

Prepared by

Carolyn L. Attneave, Ph.D. and Morton Beiser, M.D.

Department of Behavioral Sciences, Harvard School of Public Health

This material has been prepared in connection with an initial evaluation contract to appraise IHS Mental Health Programs seven years after their formal introduction into the system in 1966. (IHS Contract No. HSM 110-73-342) As originally conceived the report was to be based upon a sampling of about three programs in the eight major Areas: One outstanding, one average, and one new or otherwise struggling. Administratively, Area Chiefs of Mental Health and their staffs found it impossible to participate in such a selection, and instead the staff has been required to inform themselves about over 90 programs and present their findings about each as objectively as possible.

The chapter for each Area follows a standard arrangement of information, varying in detail as the Area development indicates. There is first a description of the geographic and cultural context within which Area programs and Service Units work. Secondly, there is a reporting of the historical roots of mental health activities in the Area as far back in time as it has been possible to find evidence of them. In some instances this is coincidental with the formation of IHS in 1955, but in most it appears a few years before introduction of formal budgetted mental health staff. The latter sections of the report develop in chronological order (usually in two year segments) the personnel and activity of the Mental Health programs for the Area. Unique and special programs are presented in detail. Finally, an overview and summary of achievements and problems yet to be resolved concludes the description of the Area, which was completed as of the spring of 1973.

The concluding chapter of the report and the extensive sections on inpatient programs will be of interest to all Areas. It is also hoped that staff in one Area will find it of value to see what other Areas have done or are facing in the way of similar problems, and differing ones. However, when need arises, or interest is focused on only one Area, it is hoped that that chapter may be used as an independent unit.

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PHOENIX AREA PERSONNEL LIST

MENTAL HEALTH BRANCH

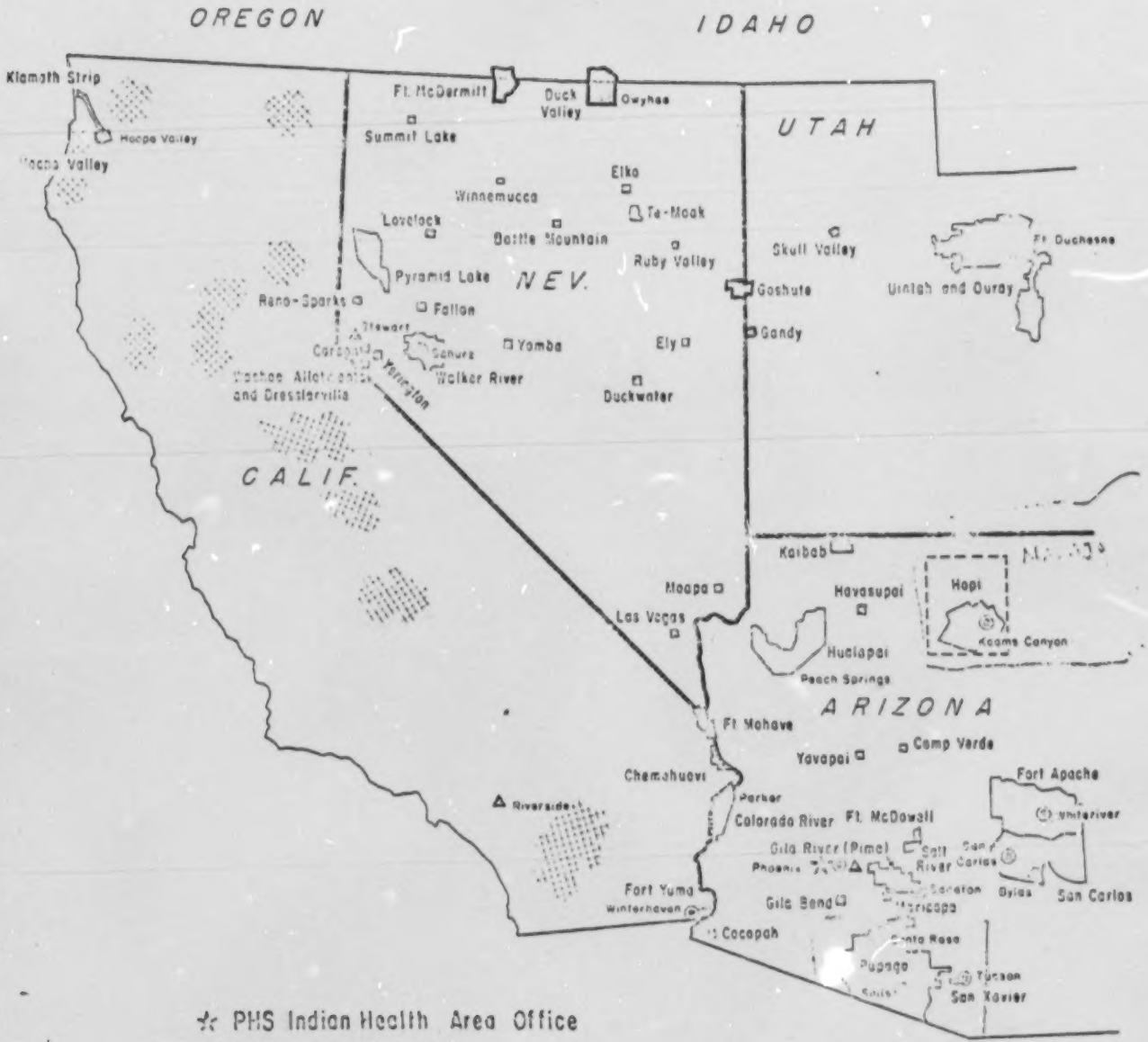
	From	To
Area		
Anthony E. Elite, M.D., Chief, Mental Health Branch	9/1/67	8/9/70
Donald Weinstein, Ph.D., Psychologist	7/1/68	6/30/70
Marjorie Myren, PHN, MPH, Chief, Mental Health Branch	7/1/69	Present
Eric Anders, M.D., Psychiatrist	7/1/69	7/23/70
Daniel Brown, Psychologist, Special Consultant	8/1/72	6/30/74
Thomas R. Burns, Alcoholism Consultant	7/1/74?	
Verdie Archuleta, Secretary	7/14/69	Present
PIMC		
Carl Hammerschlag, M.D., Psychiatrist	7/69--	
Thomas Bittaker, M.D., Psychiatrist	8/1/72	2/4/74
Violet White, Secretary		
Reno		
Stephen L. Carson, Mental Health Consultant	7/20/70	8/25/72
Priscilla N. Wachsmuth, Mental Health Technician	7/25/71	8/10/73
Dean K. Hoffman, Ph.D., Psychologist	10/1/72--	
Yuma		
George L. Raspa, MSW	10/7/70--	
Irene H. Sharkey, Mental Health Technician	5/16/71--	
PIHS		
Orville W. Merrill, Psychologist (Indian School)	12/7/70--	
Sherman		
William C. Schempp, MS	1/6/75	3/7/75
Owyhee		
Eleanor L. Jones (Racehorse), Mental Health Technician	1/10/71--	
Marvin Buckley, Recreation Therapy	5/14/72	5/73
John W. Andrews, Recreation Therapy	5/74--	
Ruby Williamson, Clerk-Typist		

	From	To
San Carlos		
Austin Titla, Mental Health Technician	1/18/71	1/3/75
William S. Hanna, Ph.D., Psychologist	5/15/72--	
Joyce Randall	4/13/75--	
Whiteriver		
Charlene M. Hill, Mental Health Technician	4/4/71--	
Dan Ostendorf, Director, White Mountain Apache Tribal Guidance Program		
Keams Canyon		
Percy Pavatea, Mental Health Technician	5/2/71--	
Stewart		
Ronald L. Willis	1/3/72--	
Sacaton		
Ronald Teed, Psychologist -- Part-time Consultant	1970	1972
Full-time	1/24/72	8/12/74
Glenna J. Pedro, Mental Health Technician	12/27/72--	
Papago		
Cecil Williams		
Gene Galvan		
(And Others)		

FEDERAL INDIAN RESERVATIONS AND HEALTH FACILITIES

PHOENIX AREA

(Arizona, California, Nevada Utah)



- ☆ PHS Indian Health Area Office
- ◉ PHS Indian Hospital
- ○ PHS Indian Health Center
- △ Indian School Health Center
- Federal Indian Reservation
- Scattered rancherias and small reservation areas

I. THE CONTEXT: GEOGRAPHIC AND POLITICAL

A. The Phoenix Area as a Whole

1. States Included

With its administrative functions centralized in Phoenix, Arizona, this Area serves part or all of four states: Arizona, Nevada, Utah and California. Nevada and California are completely within the Area, Utah is also served in the southwestern corner by the Navajo Area Office where that Reservation extends across state borders. Brigham City, Utah, the location of a BIA Boarding School north of Salt Lake City is serviced from the Billings Area Office, although most of the students involved come from the Navajo Reservation. Arizona itself is divided between the Phoenix Area Office and the Navajo (Window Rock) Area. What is approximately equal to the northeastern quarter of the state is included within the Navajo Reservation, and is separately administered. The rest of Arizona, and approximately half of its total Indian population are the responsibility of the Phoenix Area Office. This includes the Hopi, whose reservation lies wholly within the southwestern portion of the Navajo Reservation. Since there are jurisdictional disputes and unclear boundaries for the Hopi territory, it seemed wise at one point in IHS history to forestall any conflict of interests by placing the Hopi facilities at Keams Canyon under the Phoenix Area Office, even though geographically they are much closer to Window Rock. This has continued, with mixed results so far as the development of Mental Health Programs is concerned.

This vast territory is dominated by two distinctive geographic regions: The Colorado Plateau, which is made up of the western slopes

of the Rocky Mountains and the valleys associated with them, runs north and south from a point nearly opposite Phoenix and east and west across most of Utah, and extends along the familiar northern sections of Arizona where one finds the Grand Canyon and large dams, irrigation and water control projects.

The second large region is known as the Basin and Range, an arid valley punctuated by small mountain chains that lies between the Rockies and the Sierra Nevada Mountains. This vast region is the desert land of the continental United States, and includes practically all of the state of Nevada, parts of Utah, parts of California, and the southern portions of Arizona. The Basin and Range characteristics continue into northern Mexico, and long that Arizona-Mexican border it is often referred to as the Sonoran Desert.

A small tip of the Columbia Plateau extends into Nevada along the Washington, Idaho borders and is the location of the Duck Valley Reservation. The Sierra Nevada Mountains are included in the area around Reno, Nevada and of course form a major region for the state of California. A number of smaller tribes, the best known of whom are probably the Washoe, live in these mountains and relate to both Reno and the California cities for their urban needs.

As will be discussed in more detail later, most of the Indian health activity in California has not been an immediate concern of IHS during the years covered in this report. Therefore, only those populations bordering Arizona and Nevada have figured in the program planning and development of resources by IHS, and the complexity of the geography of California has not been a major concern.

The tendency at the Phoenix Area Office is to view the tribes it serves in Arizona closely, then to extend concern to the Nevada and the Utah reservations and last of all the California installastions not contiguous with Arizona. By starting in the East and moving across the Area westward, the same relative emphasis will be used to describe the factors of geography, climate, and where it seems relevant, the social context of each region before entering into a description of the historical development of Mental Health Programs within IHS in this Area.

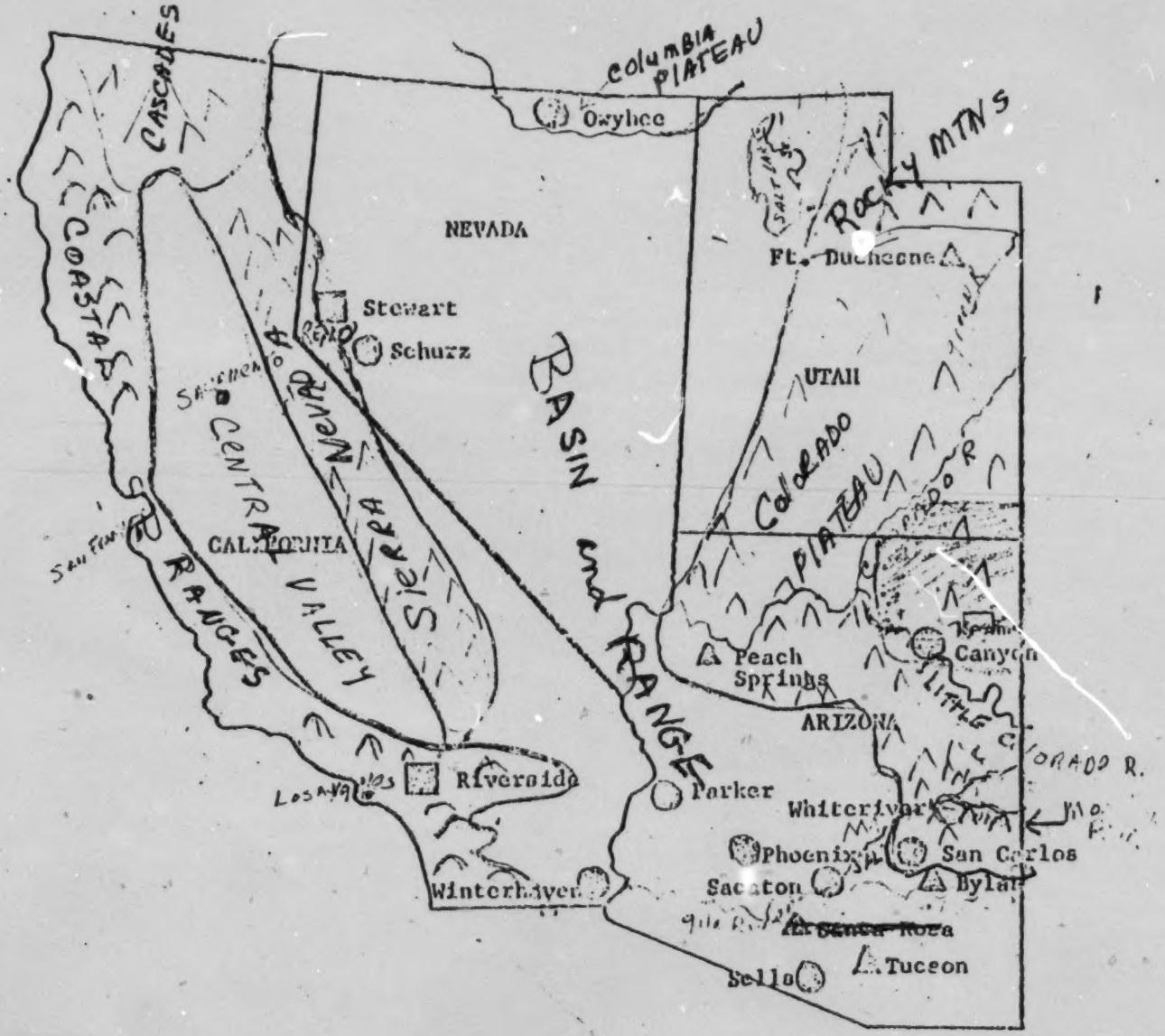
2. The Phoenix Area Office and Phoenix Facilities

The Phoenix Area Offices are located in buildings within sight of a large Medical Center and Hospital, but are not actually a part of it. The Chiefs of Programs have relatively easy access to one another, as do their secretaries and supporting technical staff. The result is a fairly harmonious resolution of problems of turf and territoriality at the top administrative level, as well as a fairly smooth flow of administrative decisions from the field of the Chiefs, and back again.

Two major facilities relevant to the Mental Health Program also located in Phoenix are the IHS Medical Center and the BIA School. The medical center is a multi-storied facility, with many inpatient and outpatient programs, which serves as a referral hospital for the Area when specialists are needed, as well as providing service to the urban Phoenix population, and the nearby reservation of Salt River. Through the Social Services branch, facilities for coordinating an outpatient program with a staff of at least one psychiatrist full-time, and another on a part time consultation basis exists. About three social workers are also available as therapists and in a variety of appropriate roles. This

GEOGRAPHIC REGIONS

OF THE PHOENIX AREA



clinic apparently consults with Hospital staff as well as accepts referrals and walk-in patients. There is planning under way for developing inpatient services within IHS, although to date inpatient arrangements have been made at both state hospitals and private facilities in the Phoenix and other regions.

About three miles down the Indian School Road from the Area Office and the Phoenix Indian Medical Center is the BIA School where an active mental health program is administered by a psychiatrist attached to IHS. Under his supervision several interns in psychology programs at nearby universities also offer counselling services to students.

From the Phoenix Indian Medical Center, the Mental Health staff are available for consultation to other reservations as will become evident in the program descriptions. The location of Phoenix as the Area Headquarters in south central Arizona, makes it most accessible to the Indian populations in the Southwestern desert, as well as providing the services to urban Indians in a major city. As a rapidly growing urban population center, many facilities, such as private and public mental hospitals, nursing homes, and educational facilities are available in Phoenix and its metropolitan area, so that the Indian population travels from all points of the Southwest to this center. No such focal installations of IHS resources are to be found in the other states of the Area, making the Phoenix combination of administrative offices and medical facilities somewhat unique.

3. Other BIA Schools

In addition to the Phoenix BIA school there are two additional BIA Schools in the Phoenix Area: Stewart Indian School north of Reno Nevada, near Carson City, and Sherman Institute, a secondary and trade school in Riverside California. IHS maintains a Health Center

at each of the schools, and mental health consultation is provided either by staff or by contract arrangements.

B. Regional Characteristics

1. The Colorado Plateau

The southwestern slopes of the Rockies extend into Arizona, and form the ranges along its northern and western portions. Much of this region, which includes a large proportion of Utah is known as the Colorado Plateau. There are high hills, mesas and valleys becoming more open in the south as well as more spectacular. The southern extremes of this region include the familiar Grand Canyon and parts of the Navajo Reservation. In general, the mountainsides themselves invite exploration and offer vistas looking across the valleys and along the peaks whose slopes seem somewhat gentler than to the east of the Continental Divide.

The Ute tribes are located on the western slopes of the Rockies at Fort Duchesne and in the valleys of the Colorado Plateau in north central Utah. The Apache Reservations, San Carlos and White River, lie in the southern portions of these mountains in eastern Arizona. All three of these reservations are characterized by forested mountains, lush valleys, and streams that flow with considerable force fed by melting snows. Hunting, fishing, mining, and potential tourism resources supplement stock raising as means of livelihood and economic development. Isolation from major metropolitan resources also characterizes these reservations, so that all-weather roads, and access to air or rail transportation becomes an important aspect of planning for their development and for delivery of services by IHS.

Not all of this Colorado Plateau Region is green and well watered however. The Navajo Reservation in north eastern Arizona also includes

arid desert as well as timbered slopes and grassy mesas. This sector is largely outside the responsibilities of the Phoenix Area Office of IHS. Even though more than 50% of Arizona's Indian population resides there, the Navajo Reservation is organized as a separate administrative unit.

However, the Health Services to the Hopi Reservation, lying wholly within Navajo boundaries, is administered from Phoenix through the IHS Hospital at Keams Canyon. The Hopi are located mainly on three steeply sided and ancient mesas, formed as the plateau eroded by water and wind. The countryside is in marked contrast to the wooded, gentler slopes of the rest of the Colorado Plateau, a factor which has helped the Hopi preserve their isolation and kept much of their culture intact.

The remaining pockets of Indian population in this region to whom IHS provides services are those living in the valleys and canyon bottoms west of the Grand Canyon, served from Peach Springs Arizona in the North west quadrant of that state. Both the Hopi and these small tribes, the Hualapai and Havasupai, share with the Apache and Ute tribes a sense of isolation. All but the Hopi have geographic settings that contrast with the arid regions that make up the vast deserts that dominate the rest of the Phoenix Area.

2. The Basin and Range: American Deserts

The Basin and Range, as the geographers designate the vast region between the Rockies and the Sierra Nevada Mountains, is the region of American Deserts. It extends east to west from mid Utah across the entire state of Nevada, and in its southern sectors across all of Arizona and parts of Southern California. It is bounded by the

Columbia Plateau on the north, formed when lava overflowed the northern portions of the Basin, and therefore its northern edges are found in the States of Washington and Idaho. To the south the Sonoran Desert. of Mexico is an extension of similar terrain and vegetation found in southern Arizona and California.

This high plateau-like country is the valley bed formed as mountains older than the Rockies eroded away under glacier action and through the silting up of the riverbeds that once flowed across them. Unlike the Rockies or Sierra's which invite climbing and exploration, the remnants of these mountains which exist as fairly isolated stubs and small chains scattered over the region, are typically viewed from the valley floor. They are isolated, rugged escarpments, particularly in the southern portions of the region, which remain mysterious and inaccessible. The Indian populations of this region often utlized the mountains seasonally for hunting or gathering of pinyon nuts (particularly in Nevada), but made only seasonal visits, preferring to live most of the time along the valley floors. The seasonal nature of their trips were often associated with religious observances, and with the gathering of materials needed for ritual and healing purposes during the rest of the year. This, together with their use as natural fortifications by raiding Indian parties, gives rise to many tales of ghosts, supernatural powers and heroic exploits. Their rather brooding appearance, together with these accrued associations, makes exploration even less inviting. Among the more famous of these, and illustrative of the atmosphere created around the mountain ranges of the Basin and Range Region, are the Superstition Mountains just outside Phoenix. Arizona. The San Francisco Peaks near Tucson seem to be

succumbing to white exploitation as sites for observatories, and even for suburban development, but few of the others have been tamed.

The Southern or Sonoran Desert is characteristically covered with large cactus--of which the Saguaro is the most famous. Organ pipe cactus and Joshua Trees also cover large tracts, some of which have been set aside as national monuments.

This southern portion of the Basin and Range is settled by the Papago Tribe, whose holdings to the west of Tucson and along the border of Mexico equal the approximate size of the state of Connecticut. The Papago have been an agricultural people as far back as historians can trace them, although they do not have a developed irrigation system. More information about their culture and customs is given in the section on the Tucson Sub-Area, in the body of the report.

Related to the Papago linguistically and culturally are the Pima whose reservation, along with the Maricopa, lies along the bed of the Gila River south of Phoenix. This tribe was not only agricultural in its culture, but had an extensive irrigation system that has been virtually destroyed by the dams and diversion of water by non-Indian reclamation projects. The traces of the ditches, canals and aqueducts can be seen across the desert, but most Pima land is useful only for "dry farming" using natural precipitation and run-off waters. Sacaton Indian Hospital is the IHS Service Unit.

The Salt River Reservation, in the foothills just north of Tucson, is facing the collision of urban development and is not served from the Phoenix Indian Medical Center as one of its satellites.

To the west, small pockets of Indian populations are located along the Colorado River and their reservations straddle the Arizona-California

border. With the exception of Winterhaven in the extreme south, the IHS facilities are all on the Arizona side of the border. These tribes, the Chemuevi, Maricopa, Mojave, and some migrant Hopi among others, are served by contract consultants for mental health services provided by IHS, with a focus at Peach Springs in the tribes such as the Havasupai living at the bottom of Grand Canyon in its western extensions. As naturally agricultural people they have tended to be ignored in their isolation or to be innundated with pressure to migrate to more urban settings, depending on the development of water resources. Except when they speak up to battle the development of further water resources for California in places which would destroy their natural living places, as was recently done in connection with a proposal to place a dam across the Grand Canyon, these tribes are relatively unknown and ignored.

In the northern or Nevada portion of the Basin and Range region the vegetation is somewhat different. In the valleys and level areas there are mesquite, prickly pear, and rough grasses suitable for grazing cattle. In the hilly to mountainous sections, pinyon and juniper are the dominant trees, along with a few other evergreens. This hilly region has been the subject of tension recently as cattle raising non-Indians seek to clear the land of the pinyon and juniper and thereby hope to increase the acreage available for cattle. This strikes at the heart of both the economy and the cultural traditions of the Shoshone and Paiute tribes who are scattered over Nevada, and who have utilized the pinyon nuts for a major food source for as long as man can remember.

Three IHS Service Units are located in Nevada—a Field Station is in Reno which has some responsibility for urban programs and also coordinates much of the work needed by the widely scattered reservations. An IHS

Hospital 100 miles away at Schurz Nevada serves the central and southern Nevada populations. Another IHS Hospital is located at Owyhee, on the Duck Valley Reservation. Duck Valley technically is part of the Columbia Plateau, along its southern boundaries - a region not unlike the Basin and Range, but covered by lava flows from the western mountains and northern Rockies during their formation period. It is even more fertile than the Basin and Range lands, and of a slightly higher elevation. Duck Valley lies across the Washington-Nevada state line, but since the Hospital serving the reservation is in Nevada, the entire reservation is included in the Phoenix Area. The population of the Duck Valley Reservation is a mixture of Shoshone and Paiute tribes, as are most of the smaller reservations scattered over the central parts of the state.

3. California

Geographically California is a varied state, well known to most people for its major features of Sierra Nevada Mountains on the east, coastal ranges and seashore on the west, and its central irrigated fertile fruitgrowing valleys. Many scattered tribal groups still live in California, as well as a large number of Indians who have migrated from reservations elsewhere. However, with the exception of the Colorado River tribes and the BIA school there has been relatively little IHS activity within the state.

In California the situation with regard to health care for Indians is quite complex. Federal responsibility for direct health care for American Indians in California was terminated in 1955 with an expectation that the State of California would assume the responsiblity for the health needs of its Indian citizens. In fact since 1955 there has been a general deterioration of health care for Indians up until recently when

there has been some slight improvement.

The Indian population in California is numerous. Descendants of original Californian tribes still exist, some on scattered and isolated rancheros and reservations, others as urban migrants in the cities. In addition the Los Angeles, San Jose and San Francisco Bay areas have large numbers of American Indian migrants from all over the United States who have come to seek urban employment opportunities. Because of this dispersal and scattering of Indian peoples, there is no convenient or efficient focal point for delivering Indian Health Services to these people.

In recent years (since 1969) several factors have resulted in increased attention to the special health needs of Indians in California. The California Rural Indian Health Board was organized in June of 1970 and incorporated as a non-profit organization. The purpose was to establish health clinics on reservations where there were still some substantial numbers of Indian people to be served. Funding for these clinics has been from federal grants with supervision from the Indian Health Service. The effect of this program has been to reestablish a federal responsibility for Indian Health but through an Indian-controlled non-profit corporation.

Following the successful model of the Rural Indian Health Board, a California Urban Indian Health Corporation has been incorporated to provide the impetus for establishing urban Indian Health Centers. CUIHC has become a conduit for federal funds to a number of urban Indian Health Centers in major population areas such as San Francisco, Sacramento, and Los Angeles.

Both the CRIHB and CUIHC programs have emphasized general medical

services such as well-baby clinics and dental services but have not placed a priority on mental health services. However the service delivery systems represented by these programs has the potential for incorporating a variety of mental health services and some such as alcoholism programs are being started. Psychiatric consultation to a cluster of Urban Health Centers in the Los Angeles Area is being offered on a part time basis.

II. CENTRALIZED DEVELOPMENT OF MENTAL HEALTH PROGRAMS IN THE PHOENIX AREA

A. 1967-1969: Anthony Elite, M.D., First Mental Health Area Chief

In 1967-68, two years after the initiation of Mental Health Programs on a formal basis, Anthony Elite, M.D., was recruited to IHS and assigned to the Phoenix Area Office as Chief of Mental Health Programs. His mission was to explore the possibilities of developing mental health services. His first year was spent largely in visiting about the Area in an effort to understand the needs both of the populations to be served and the IHS staffs already active in other programs of service delivery. During this period he was available while visiting for consultations with Service Unit staffs, although there are no Area Office records of direct services being provided.

When not out in the field, Dr. Elite spent time planning and developing coordination within the Area Office. He developed an appreciation of the needs of several Program Chiefs for cooperative resources of the type usually offered in a mental health program. He also found it possible to plan ways in which training and staff development patterns could be initially organized. These ideas were set down in a detailed program of objectives, paired with assigned responsibilities and actions for implementation. This plan, drawn up in December 1967, while not followed conscientiously as one might follow a blueprint in building a house, nevertheless provides the outlines of what have become the important aspects of the Phoenix Area Mental Health Program. For these reasons it is included here, slightly recast into a form which is compatable with identifying objectives and distinguishing methods to be used in accomplishing them.

SECTION V MANAGEMENT/ADMINISTRATIVE PLANS - MENTAL HEALTH

STATEMENT OF THE HEALTH PROBLEM:

It is necessary at this time to tie together various aspects of what can be termed Mental Health Programs into a unified area wide mental health program which is an integral part of the comprehensive health program.

DEFINITION:

Mental Health can be defined as the quality of coping with life around us; that is, with our life situation. The level of mental health of an individual or a group is determined by physical, intellectual, environmental, constitutional, and emotional factors. The essentials for high level of mental health include basic sustaining requirements of food, clothing and shelter, freedom from physical and emotional illness, having the capacity to adopt to change, deal constructively with reality, relate in such a manner with others within the community and outside the community in a consistent mutually satisfying give and take relationship.

Therefore, an effective mental health program is one designed to identify problem areas and to systematically plan the investigation of the problems, accumulate available resources, organize them in some meaningful interrelationship geared to attaining positive mental health goals, and finally, explore new techniques and approaches to solving individual and community mental health needs.

STATEMENT OF ACTIONS

To assist in the organization, development, and implementation of area wide mental health programs.

I. OBJECTIVE No. 1

Improve data collection systems documenting mental health problems for purposes of identifying problem areas, priorities, and increasing staff awareness of the problems.

Action Statement No. 1

Encourage all medical officers and health records personnel to accurately document and code psychiatric diagnosis. Encourage collection of mental health data on all patients admitted to PHS Hospitals and those seen in OPD.

Responsibility Distribution

Service Unit Director - Medical Officers, and Medical Record Librarians, would use appropriate APA classification. Whether this is primary diagnosis or secondary, this should be reported so as to be available on an area level.

Action Statement No. 2

Encourage Social Workers and Public Health Nurses to document problem families and individuals they encounter in their routine activities.

Protocol to be Used

Standard APA nomenclature.

Mental Health Data Collecting Sheet (currently being tested at Sacaton)

Area of Responsibility and Content

Responsibility Distribution

Service Unit Director - Content for any additional method of data collection should be determined by primary staff.

Action Statement No. 3

In areas already described as problem areas, encourage further documentation of the studies as well as development of similar studies on other reservations.

Responsibility Distribution

Health Educator, Anthropologist, local aid.

Secondary Staff

Local informants, tribal health committees, translators.

Protocol to be Used

The Mail and Hayes studies can be used as a base for further alcohol studies on San Carlos Reservation. Encourage health educators on various reservations to use their approved protocol.

Content and Area of Responsibility

Content to be determined by team. Responsibility to be the team leader's whether anthropologist, health educator, or other professional research person.

II. OBJECTIVE No. 2

Development of a mental health consultation team at the area level which can function in various ways depending upon the needs of the individual service unit. Such functions might include diagnostic evaluations, crisis intervention, service unit staff consultation, staff training, mental health supervision, mental health education, mental health program planning and program consultation and training of MH workers.

Action Statement No. 1

a. Methodology

Diagnostic evaluations - Utilization of available professional resources for psychiatric evaluations in those cases where such service is needed. Promote good working relationship between Service Unit staff and local community mental health clinics where they exist. Provide limited services directly in areas where no such resources exist.

Responsibility Distribution

Primary Staff Involved (a)

Area Mental Health Team, Service Unit Director, and Social Worker.

Secondary Staff Involved (a)

Public Health Nurse.

Action Statement No. 2

b. Methodology

Crisis Intervention - Develop mechanisms for handling of acute crisis situations which might develop on the reservation. This could range from telephone consultation to staff, to providing brief crises-oriented treatment for individuals or groups when possible and indicated.

Responsibility Distribution

Mental Health Team, Service Unit Director, Social Worker, Public Health Nurse.

Action Statement No. 3.

c. Methodology

Service Unit Staff consultation: Provide consultation to any staff member at the Service Unit concerning problems of management of individual patients, groups or on any aspect of the Service Units' Mental Health Program. This includes mental health programs outside of the hospital such as school health programs and tribal community development projects.

Protocol to be Used

Consultations could be set up on an individual or group basis. These could be on an informal, as needed, basis or at regularly scheduled field visits of the mental health team.

Responsibility Distribution

Primary Staff

Area Mental Health Team.

Secondary Staff

Service Unit Director, Medical Officers, Nurses' aides, Social Worker, Health Educator, school teaching and guidance staff, tribal community programs' staff, tribal health committees.

Action Statement No. 4

d. Methodology

Staff Training: Provide training in mental health concepts and approaches to Service Unit staff in either group or individual sessions. Set up area-wide workshops on Mental Health. Help staff members learn how to recognize mental illness and when to make a referral for psychiatric evaluation and at the same time help them learn techniques on dealing more effectively with disturbed patients and their families.

Responsibility Distribution

Area Mental Health Team, Health Educator, Hospital and Field Medical staff.

Action Statement No. 5

e. Methodology

Mental Health Supervision: Provide supervision to Service Unit staff members in the management of crisis situations among the indigent population as well as provide follow-up consultation with staff members who continue to deal with individuals and families presenting emotional dysfunctioning.

Responsibility Distribution

Area Mental Health Team

Action Statement No. 6

f. Methodology

Mental Health Education: Provide for development of mental health education and training programs on an area-wide level. Plan local Service Unit based mental health worker program where local, Indian individuals from the community who demonstrate empathy, sensitivity, integrity, and skills in dealing with his own people can be trained in basic mental health skills and techniques. This person eventually can become a key member of a Service Unit based mental health team. This aide could eventually do follow-up visits with patients discharged from mental hospitals and mental health clinics as well as work with alcoholics and their families in the community or home setting.

Responsibility Distribution

Primary Staff

Area Mental Health Team, Health Education Specialist, D.I.H. Training Center in Tucson.

Secondary Staff

Contract Educator and Trainees from the Phoenix Area, CHR trainees.

Action Statement No. 7

g. Methodology

Mental Health Program Planning: Provide an ongoing operating scheme whereby existing mental health programs can be evaluated and plan for future developments coordinated with the existing program plans. Professional skills also will be made available to Service Unit staff, so as to give them technical assistance in their own mental health program planning.

Responsiblity Distribution
Primary Staff
Area Mental Health Team.
Secondary Staff
Area Program Services Branch Chiefs

Action Statement No. 8
h. Methodology
Program Consultation: Provide consultative services to any of the Area staff on all or any aspects of the total health program which is in any way related to mental health.
Responsibility Distribution
Primary Staff
Mental Health Program Director
Secondary Staff
Other members of Area Mental Health Team as designated by Branch Chief.

III. OBJECTIVE No. 3

Propose a prototype, broad based, multidisciplined mental health program that concurrently attacks all factors contributing to poor mental health in the beneficiary population in a designated community.

Methodology:
The need for a concerted, coordinated joint action and support at the Area, as well as the Service Unit level, is strongly felt. A scheme whereby mutual participation in the form of an Area team or Ad Hoc Committee is suggested. This team composed of Area Chiefs of Mental Health, Social Service, Health Education, and Nursing, should be given the responsibility as well as commensurate authority, for development of a study design, organization, evaluation, reporting and coordination of the project. Once a specific location and Service Unit has been selected, the Committee could add the Service Unit Director and Tribal Health Representative and BIA staff to the Area team.

Action Statement No. 1
Program Proposal:
Phase I - FY 1969
1. Development of a prospectus including resources, document, preparation of a budget, delineation of responsibility, etc.
2. Identification of the problems.
3. Development of protocol.
4. Evaluation

Phase II - FY 1970 - Future
1. Testing of protocol
2. Adapting and adjusting protocol as needed.
3. Putting program into action.
4. Evaluation

Phase III - FY 1971, 1972, 1973
1. Continue Program Action
2. Evaluation
3. Documentation

Phase IV - FY 1974
1. Documentation
2. Recommendations
3. Summary and Conclusions

Responsibility Distribution
Primary Staff:
Area Branch Chiefs: Nursing, Mental Health, Social Service, Health Education. (Later) Service Unit Director and Tribal Health Representative.
Secondary Staff:
Area Mental Health Team. Contract services from available resources in the area.

*NOTE:

This program does not conflict with the Area-wide Mental Health Program actions previously mentioned. This proposal is designed as a prototype program utilizing concentrated broad based but high level skills on a local level as a demonstration project of a truly comprehensive health program. The broadest scope of this approach can most effectively be obtained through multidisciplinary participation.

By the spring of 1968 Dr. Elite had become sufficiently familiar with the potentials and problems in each Service Unit to prepare capsule summaries of the status of mental health services provided through the Social Services Branch, the local alcoholism programs, contracts with institutional and private psychiatric services. These capsule summaries are cited in the subsequent sections, which develop the description of local programs. However, the general introductory paragraphs to this report summarize succinctly the status of mental health programming at that time. They are therefore quoted below:

> The current status of mental health in the Phoenix Area of the Division of Indian Health is essentially in the early development stages. Facilities and resources are about as reported last year; however, there seems to be a genuine increase in interest and concern about mental health, not only among service unit personnel and the Bureau of Indian Affairs, but among the Indian beneficiary population. Since my arrival in Phoenix in 1967 as the first mental health program officer, I have spent the greater part of my time discussing mental health concepts and programs with service unit staffs, BIA and tribal health committees, as well as attempting to open channels of communication between DIH and other local, state and federal agencies concerned with mental health planning and delivery of services.
>
> Before I branch off into a descriptive analysis of the status of mental health on various reservations, let me emphasize the point that we do not have sufficient quantity or quality of data from the service units to present an accurate picture of the prevalence of pathology as it exists today. It is hoped that in the future these kinds of valuable information will be routinely reported by each service unit.* However, I feel we can make some gross evaluation of the mental health picture on each reservation and from this establish certain priorities where mental health programming is being concentrated.

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* Dr. Elite's observations about the lack of epidemiologic and other information about mental illness among Indian population deserves comment. This observation was not unique to the Phoenix Area, but was true in every Area of IHS, and continues down to the present (1974). The introduction of an automated reporting system in fiscal 1974 should begin to remedy this deficiency, at least in terms of problems seen by IHS Mental Health and Services staff. Population-wide demographic studies are another matter, and only on the Papago Reservation in connection with a special programming situation for health information systems, is this type of study being approached. Those programs with closest relationships to tribal roots -- advisory programs, development of Mental Health Workers, or tribal contracts -- most closely approach the expectation voiced by Dr. Elite that some study of local needs would become a regular part of local Service Unit tasks.

B. 1969-70: Marjorie Myren, RN, MPH, New Chief of Mental Health Programs

1. Increase in Staff

Due to the successful description of program needs and potentials, as well as increasing federal support avaiable, Phoenix Area staff increased threefold in 1969. Although Dr. Elite had fulfilled his military obligations he remained an additional year. However he wished to be freed of administrative details in order to concentrate on his role as psychiatric consultant. A second psychiatrist became available at this time. Eric Anders, M.D., who was on a Mental Health Career Development Fellowship, elected IHS service. Both Dr. Elite and Dr. Anders flew small planes, giving them speedy access to the far flung Service Units and earning them the affectionate title of "Our Flying Psychiatrists".

The Chief of Area Mental Health Programs position was assigned to Marjorie Myren, a nurse with extensive public health and psychiatric nursing background, and many years of study in the field of developing mental health and community health delivery systems. During her first year she also spent considerable time as a field consultant to the Service Units, familiarizing herself with the reservations, the health facilities and the tribal populations.

2. Description of Program

The third member added to the Phoenix Area staff was a psychologist, Donald Weinstein, M.S., who for much of his time filled the same role of traveling consultant as the psychiatrist and the Area Chief. Mr. Weinstein also assisted in handling the administrative detail, since like all three other Mental Health staff he was based in the Phoenix Area Office. He was responsible for preparing the Annual Report for Mental Health Programs

for the year 1970. Since this is one of the few records available from this period, it is quoted here in full. It gives a clear description of the manner in which the centralized staff was attempting to develop a broadly conceived program which would interlock IHS facilities with local resources in the mental health field.

MENTAL HEALTH BRANCH

I. Philosophy & Rationale

Due to the nature of the size of the Phoenix Area, the philosophy of the Mental Health Branch has been to have Service Units utilize and integrate with local mental health facilities. To this end, the Phoenix Area Service Unit are receiving mental health services from county clinics, state clinics, private psychiatrists and local universities.

II. Aspiration: Historical, Current, Future

A. Immediate Need:

The most immediate need at the inception of the mental health program was to locate mental health resource people for the acute psychiatric problem on reservations. This was accomplished by contracting with local facilities, arranging for private psychiatrists to see patients on a fee for service basis; lastly, and perhaps most importantly, the Mental Health Branch felt that another way of dealing with patients in crises is by supplementing the ability of the existing Service Unit Staff.

B. Tribal Awareness:

An all out attempt to elicit tribal involvement in the recognition and identification of the specific mental health problems of their people is part of the on-going Area Wide Program. To meet this goal the mental health team has been conducting a series of community mental health workshops on several reservations.

The workshops are conducted in the following manner:

The first in the series is concerned with general problems of mental health and mental illness. No attempt is made to single out specific problems of living on the reservation. A plea for community involvement is emphasized. The mental health consultants define their role to the people as outside professional consultants, skilled in the amelioration of mental health problems. The consultants are not to be viewed as experts on the reservation.

This leads into the format of the second community workshop. This conference takes the form of a discussion of specific problems of living. This specific problems discussed are those identified by the Service Unit Staff (i.e., emergency room records) as the mental health problems of that reservation.

An attempt is made to have the community participate in identifying and discussing the mental health problems of their community as they view them. Usually the last in the series of workshops is directed at what the community can do in relation to their specific problems. This takes the form of do's and don't's for non-professional workers.

C. Create an atmosphere of awareness of the mental health needs of the local people by the Service Unit Staff.

Another major facet of the Area-Wide Program is to help the Indian Health Service staff be cognizant of the cultural emotional needs of the indigenous Indian community. To this end, in-service lectures, informal discussions and staff workshops are conducted.

D. Create mental health committees at the three boarding Schools.

1. The BIA Boarding Schools at Stewart, Nevada; Riverside, California; Phoenix, Arizona are the focal points of much energy and diplomacy.

The objective was to organize a viable mental health committee at each of the schools. The functions of this committee would be to scrutinize the total environment of the school and its effect on the Indian child. Much has been published in regard to the nature of the boarding schools. It is sufficient to say that much work needs to be done in these residential centers. As in the reservation community, the most immediate need was for the boarding school staff to recognize that many students arrive at their schools with social and emotional problems, and that in many cases there is an exacerbation of the problems in the boarding school setting. These committees are a joint effort of the BIA in the Indian Health Service. The mental health team are ex officio members of each of the three committees.

E. Create mental health committees and begin involvement within the elementary boarding schools in the Phoenix Area.

No Progress.

III. Current Progress and Problems

A. Service Units

The primary approach in dealing with the Service Units is to implement the action statements that they have defined in the Service Unit Program Plan.

Because the Mental Health Branch has no designated counterpart on the Service Unit, it is difficult to implement and follow up many of the programs initiated. On some of the Service Units, the hospital social worker takes on the job of the mental health field worker. It is interesting to note there is a general fear and apprehension regarding mental health and mental health personnel by the Service Unit Staff. This, therefore, makes it more difficult to implement mental health program.

Recently some of the physicians have been asking the mental health consultants to interview patients with them. This enables the consultants and physicians to discuss a management plan and encourages the Service Unit Personnel to see patients on their own. In many cases, the public health nurses are actually the field therapists in regard to family consultation and follow up for psychiatric problems.

B. Boarding Schools

Once the three mental health committees were established in the series of mental health workshops and conference were initiated.

1. The first conference entitled "An Exchange of Ideas" was held in Phoenix, Arizona.

2. Second conference was conducted in conjunction with the NIMH Center for Studies of Suicide Prevention in Reno, Nevada.

3. The third workshop will be held in Riverside, California on December 10-11, 1969.

With the recent addition of Mr. Ray Sorenson, BIA, Assistant Area Director (Education) we now have a counterpart in the Area Office with whom to relate. This should help to foster the advancement of attitudes in program for better mental health in the boarding schools. To date, no evaluation has been made as to the effect of the mental health committees at the boarding schools. Staff impression have been that the personnel on the committees have begun to re-evaluate the very existence and philosophy of the boarding school concept.

C. Tribal Consultation

The focal point of approach to the tribes, historically, has been through the tribal health committee and is currently through the CHR's and health counsels. The mental health program staff views the CHR's as mental health field workers. Because many of the workers see the necessity for additional training in mental health work, we spend a good part of our field trips working with the CHR's. At the last Area Indian Advisory Board meeting in the spring of 1969, it was quite satisfying to hear the tribal leaders report that mental health problems are their number one health concern. This indicates to us that our approach to the tribes has begun to bring dividends. That is to say, recognition of the problems have begun. In another aspect of our tribal involvement has been working closely with the Nevada I.T.C. Alcoholism Program. As with the CHR's we view the alcoholism counsellor as front line mental health workers. It is only fair to add that we have been dilatory in our relations with the Uintah and Ouray Tribal Alcoholism Program. Our defenses are that men and monies do not permit us to service Utah as indefensively as we do Nevada.

D. Desert Willows Training Center

Due to the proximity of the Phoenix Area Office to the Division Training Office at Desert Willows, the mental health team has taught the mental health component of the CHR curriculum. The mental health team is also available to the Desert Willows staff for any other consultation and evaluation in which they wish to utilize us.

E. Miscellaneous

1. Industrial Development District of Arizona. The Mental Health Program Personnel perform as consultants in all aspects of mental health to this non-profit Indian-run corporation. Example of our involvement are: Mount Lemon Project in Tucson, Arizona and a proposed grant for Crises Intervention Center in Arizona.

2. Arizona State University - I.C.A.P.

   Periodically we are asked to consult with the I.C.A.P., usually in regard to training workshop for our headstart personnel.

3. B.I.A.

In addition to our involvement in the B.I.A. Boarding Schools the mental health team is working in conjunction with the B.I.A. Area Office, Law and Order Branch. Our involvement has been in such as:

1. Mt. Lemon, another I.D.D.A. sponsored program,
2. S.T.O.P., (Southwestern Tribes on Prevention) and
3. lastly, in-service Education for tribal police on reservations.

F. One challenging problem is the abstract nature of a mental health program, the evaluation and criteria of success is a most difficult thing to determine within the field of mental health. This problem manifest itself in determining to target date for program plans, evaluation of workshops, impact and effect of field visits, etc.

Unlike the dental program we are unable to predict the number of people to be seen, the amount of professional time needed, and the eventual outcome performed. This problem is one that faces mental health personnel throughout the profession.

IV. Contracts and Agreements for Services

A. The following is a brief accounting of the contracts and agreements arranged for the Phoenix Area Service Units.

1. University of Arizona

Department of Psychology is under contract with the Sells Service Unit to conduct a mental health clinic on the reservation.

2. Arizona State University

The Psychological Educational service under the direction of Phillip Gaffney, Ph.D., has agreed to do psychodiagnostic testing on the reservation in Arizona at a reduced rate for the Indian Health Service.

3. University of Nevada

The Nevada Service Units have recently begun utilizing the services of the Department of Psychology for pshcyodiagnostic testing.

4. University of Utah

The Department of Psychiatry has expressed interest in the Roosevelt Indian Health Center. They would like to arrange for their residents to have field experience working with the Indian population on the Uintah and Ouray tribe reservation.

5. State and County

A. Pinal County Mental Health Association

The Pinal County Mental Health Association psychiatrist spends one-half day each week at the Sacaton Hospital.

B. Northern Arizona Comprehensive Guidance Clinic under the direction of Ronald Peterson, Ph.D.

The N.A.C.G.C. has arranged with the White Mountain Apache tribe to open a local mental health center in order to provide services and train indigenous mental health workers. This program was initiated by the tribe. The expected date of commencement is January 1970.

In looking to the future Dr. Peterson has been in touch with the Hopi Tribal Council to establish a similar clinic at Oraibi. This clinic is still in the planning stage.

6. Graham County Mental Health Association

The facilities at the Graham County Mental Health Association are available and are utilized by the San Carlos Apache Tribe. There has been some difficulty in orienting the clinic staff to the cultural needs and problems of the San Carlos Apache Tribe. An attempt is being made to cement better relations with the clinic.

7. Nevada State Bureau of Community Service

The Bureau of Community Service conducts field clinics in numerous areas of the State of Nevada, although to date utilization of these clinics have been sparse. The Nevada Service Units are being encouraged to utilize these facilities.

8. Verde Valley Clinic

To be negotiated.

B. Inpatient Facilities

1. Arizona, Nevada and Utah State Hospitals

Self-explanatory.

2. Camelback Hospital - Phoenix, Arizona
Director - Otto Benheim, M.D.

C. Private facilities that are currently utilized by the Phoenix Area Service Units.

1. Arizona Children's Home - Tucson, Arizona

2. Valley of the Sun School - Phoenix, Arizona

3. Accommodation School - Phoenix, Arizona

4. Jane Wayland School - Phoenix, Arizona

5. Yuma Child's Guidance Center - Yuma, Arizona

6. Drs. James Kilgore & Otto Benheim are under contract for general medical and surgical patients with psychiatric problems at the Phoenix Indian Medical Center.

7. Dr. William Maier - Child Psychiatrist under contract with the pediatric department at the Phoenix Indian Medical Center.

8. Psychologist - Various psychologist are paid a fee for service for psychodiagnostic testings.

9. Dr. F. LaMarr Heyrends, Psychiatrist from Boise, Idaho travels to the Owyhee Service Unit, one-day per month.

In association with him, the Phoenix Area Mental Health Branch has hired Mrs. Janice Sorabella, MSW, on a part-time basis.

10. Dr. Kinne Tevis is the contract psychiatrist at the Phoenix Indian High School.

11. Dr. James Barter is the contract psychiatrist at Stewart Indian School.

12. Dr. Guy Smyth - private psychiatrist in Flagstaff, Arizona conducts a mental health clinic at the Peach Springs Center on a weekly basis.

13. Dr. Robert Brown - private psychiatrist, Reno, Nevada; is utilized as the needs arise by the Schurz Service Unit.

14. Lyman Ravsden, Ph.D. - is a Clinical Psychologist who provides service on the Uintah and Ouray reservation subsidized by the Indian Health Service in-conjunction with the B.I.A. and State of Utah.

V. Miscellaneous

A. Demonstration Clinics

1. Three members of the Mental Health Branch are conducting community mental health clinics at Gila Crossing, Salt River and Ft. McDowell. The fourth member of the Area team is working in training pediatric residence at the Phoenix Indian Medical Center.

2. Nursing In-service Education

A. The mental health team has conducted two-15-hourly session and one-6 week hourly session with the nursing staff of the Phoenix Indian Medical Center.

B. The Mental Health Branch in cooperation with the Nursing Branch is in the process of conducting three Regional Mental Health Workshops for nursing staff personnel.

III. 1970-72: DECENTRALIZATION AND THE INTRODUCTION OF MENTAL HEALTH TECHNICIANS

A. Professional Staff Changes

At the end of 1970 Dr. Elite and Dr. Anders both left the IHS. Dr. Elite entered private practice in the San Francisco Bay area, while Dr. Anders elected to spend the rest of his Mental Health Career Development Fellowship with the Peace Corps in Malaysia. While there had been four professionals available the Phoenix Area had been divided into four regions, each served on a regular schedule by one of the Area Office Consultants. However, this proved too demanding and comments about this period suggest that not only was the travel time a problem, but that time spent "re-entering the system" when visits to a reservation were a week or more apart was wasteful and distracting from the tasks of establishing consulting and clinical relationships.

Carl Hammaschlag, M.D., was recruited as a psychiatrist in 1970, and assigned half time to the traveling consultant role and half of his time was alloted to the BIA school. A psychologist was given a full time assignment at Sherman Indian School in Riverside, California. Neither were attached to the Area Office, as had been the custom with previous professional staff.

B. Mental Health Technicians

In addition a program of recruiting and training mental health technicians was initiated and a number of local contracts were developed. These changes are given highlighting in the annual report for the period ending June 1971, and forwarded to the Area Director.

C. Excerpt of Annual Report Fiscal Year 1971

Staffing:

The Mental Health staff grew from four positions in 1970 to 12 in FY 1971, in addition we had one mental health consultant assigned to the Area from the NIMH-MHCD program. Formerly all the mental health consultants worked out of the Area office. This past year we decentralized and personnel were stationed in the field. This has allowed us to work more closely and effectively with the Service Units and Indian people.

Six Indian Mental Health Technicians were added to the staff. Training rather than service is being emphasized during their first year on duty. Their first five week phase of training was completed at Desert Willow Training Center in June, 1971. The second phase at DWTC will be held in October, 1971. On the reservation level, the MHT's are training under a preceptor who is either a mental health consultant or medical social worker. They are following the Social Work Associate Lesson Plans in addition to participating in other meaningful learning experiences on the reservation level.

The first full time mental health consultant was added to the staff of Sherman Indian High School this year. With the cooperation of the BIA staff he was able to implement a mental health program which was well received by students and staff alike.

Bi-weekly mental health consultation was provided to Whiteriver, San Carlos, Parker and Yuma by Eric R. Anders, M.D., our flying psychiatrist. Dr. Anders also held a weekly mental health clinic at Gila Crossing and worked with the staff of PIMC on their alcoholism program. Dr. Anders was assigned to us from the NIMH-MHCD program and left June 30, 1971 for Malaysia and the Peace Corps.

Professional mental health consultants were also added to Phoenix Service Unit, Reno, Nevada and Yuma, Arizona. The psychiatrist at Phoenix Indian Medical Center devoted the major part of his time to Phoenix Indian High School, weekly mental health clinics at Salt River, weekly conferences with the social work staff at PIMC and in addition participated in training sessions throughout the area. The Reno psychologist divided his time between Owyhee and Schurz Service Units and the Yuma psychiatric social worker served both Parker and Yuma Service Units.

In addition to IHS staff we contracted for mental health services as follows:

a) Mohave Mental Health Clinic; Kingman, Arizona (1/2 day per week at Peach Springs, Arizona)

b) F. La Marr Heyrend, M.D., Boise Idaho (Psychiatric consultation - monthly - Owyhee, Nevada)

c) James Barter, M.D., Sacramento, California (Psychiatric consultation - monthly - Stewart Indian High School)

d) Lynn Ravsten, Ph.D., Provo, Utah (Fort Duchesne, Utah - weekly)

e) Kinne Tevis, M.D., Phoenix, Arizona (Psychiatric consultation - weekly - Model Dormitory - Phoenix Indian High School)

f) James Kilgore, M.D., Phoenix - Phoenix Indian Medical Center

g) Otto Benheim, M.D., Phoenix - Phoenix Indian Medical Center

Contracts with Tribal Councils

A contract was made with the Tribal Council of the Reno-Sparks Indian Colony as a follow up of an Epidemiological Study of Their Youth. The Council identified and set up a program for 20 potential school drop outs. The latter were each assigned a University of Nevada student who acted as a tutor and model. Positive relationships were established between all but two of the pairs. Los self-esteem and not lack of ability was thought to be the Indian High School students' major problem. The program was thought to be successful and the contract will be renewed in FY 1972, with some basic changes. The Chairman of the Tribal Education Committee stated "we learned a h--- of a lot this year" and will be able to carry on a more effective program next year. Another contract was developed late in the year with the Walker River Paiute Tribe for preventive mental health program for their youth. The objectives of this program are to increase student's self-awareness as an Indian of worth and dignity, to increase his achievement goals, to motivate him to remain in school and to improve communications between the youth and adults.

Mental Health - Medical Social Work Branches

The Medical Social Workers were the prime contact persons for the mental health consultants at the Service Units during the year because of closely related interests and roles. The MSW's are preceptors and supervisors for the mental health technicians on three of the reservations. The MSW's were included on the curriculum committee and preceptors training sessions at DWTC, as well as attending the annual IHS-MH meeting and selected training sessions.

Tribal Mental Health Committee

The Owyhee Mental Health Committee which is a volunteer body of tribal members existing under the authority of the Shoshone-Paiute Business Council has been very active this year. They are interested in reducing the suicide rate among their young men and raising the general mental health of the community. Among their activities, they sponsored a suicide prevention workshop conducted by the staff of the L.A. Suicide Center and also have submitted a proposal for a preventive mental health program for their youth. The latter would be directed by a full-time IHS Recreational Therapist.

The WhiteMountain Apache Mental Health Committee is also active. They received a grant from NIMH in FY 71 to establish their own mental health clinic. In FY 1972, they will hire a full-time mental health consultant with the addition of IHS, State and Tribal funds. The Tribal Mental Health Committee and Service Unit staff have been working on a protocal for interagency management of patients and families with mental health needs.

D. Training Activities

From this report it is evident that by the summer of 1971 the number of staff involved and the quality and extent of programs had developed from the embryonic stages described by earlier reports to nearly a dozen fairly complete programs located throughout the Area. It is not surprising, therefore, to find that a heavy emphasis at this time was put on training through the Area Office. An impressive number of workshops, seminars and courses was attended by all levels of staff, with expenses paid by the Mental Health Program budget or the Area training budget. Included in these activities were contract consultants and others whose roles were a key to community and tribal coordination, or in some other manner essential to local and Area programming. Some of these training sessions were the following: Suicide Prevention workshops in Los Angeles, and also at Owyhee, Nevada; School Mental Health workshop held at Lake Tahoe; five staff members attended Alcoholism workshops held at such locations as the University of Utah, Atlanta, Georgia, and Boston,

Massachusetts; and four others attended seminars or workshops of particular interest to themselves and their local responsibilities in the areas of communications, youthful offenders, and dying patients.

In addition to these learning experiences, the staff also held regular meetings for the exchange of information, discussion of administrative policy, etc., at both the Area and National level. Orientation of new staff (both contract and regular IHS employees) was considered a legitimate training function as was a special meeting of those IHS staff who served as preceptors for the Mental Health Technicians. The three largest items in this Mental Health training budget are for the month's support of the Mental Health Technicians during their basic training course at Desert Willow Training Center, and for two workshops in which IHS staff presented materials and information to a larger mixed group of participants: the workshop on School Health and the workshop on Suicide Prevention held at Owyhee. This, as in the preceding description verifies the fact that "training" was defined as going both directions--inservice training opportunities and training offered to colleagues and to associates outside IHS.

IV. 1972-73: CONSOLIDATION

A. Annual Report

This general commitment to training, and an appreciation of the need for staff to secure new perspectives and new skills by studying for shorter or longer periods of time away from their usual assignments still characterizes the working policies of the Phoenix Area, at least to the extent that external controls on funds permit. Orderly progress is indicated by another succinct statement which summarizes the program highlights for the following year (FY 72):

General

The Phoenix Area mental health program continued to expand during FY 1972. Program emphasis has been on recruiting for qualified mental health consultants to provide leadership in developing mental health services on the reservations and in the BIA boarding schools, mental health training and individual therapy and primary prevention on the reservation level.

Mental Health Technician Training

There were significant changes in the MHT training program during the year. The course is now accredited through Central Arizona College. Training is conducted at Desert Willow Training Center, on the reservation under a preceptor and at Central Arizona College. Trainees will receive an associate of arts degree after successfully completing two years of training. If the MHT desires he may then apply to a university to work toward a higher degree. The mental health technician training program is optional, however, and the individuals can work toward an IHS certificate rather than college credit if they desire. MHTs in the training program have been primarily from the Phoenix area, either IHS, BIA or Tribal employees. Four trainees from other areas participated in the program and it is open to any area who would like to participate.

Mental Health Programs in BIA Boarding Schools

Mental health consultant positions were obtained for the three BIA Boarding High Schools in the area. The psychologists are working closely with the Superintendents and administrative staff. The three school mental health programs appear to be developing effectively.

Tribal Programs

Contracts were made with five tribal councils for Preventive Mental Health Programs For Children & Youth. These are pilot projects. The Tribal Councils had no traditional programs to use as a model. The

programs are developing in a variety of ways. The Indian people involved feel primary prevention programs will help their youth learn to effectively cope with problems of living. They are looking for on going funding for such activities.

Training Sessions

Among training sessions sponsored by the Mental Health Branch were the following:

Fort Duchesne: Crisis Intervention Workshop. Purpose of this was to train Indian people to man a 24 hour "Hot Line" for the reservation.

DWTC: Three day mental health seminar for Phoenix Area Advisory Health Board.

Reno: Crisis Intervention Training Workshop for CHRs and Alcoholism Counselors.

Phoenix: Weekly Experential Sessions for Indian leaders conducted by PIMC psychiatrist.

New Staff Recruited

Dr. William Hanna, Psychologist, San Carlos.
Dr. Ronald Teed, Psychologist, Sacaton.
Mrs. Glenna Pedro, Mental Health Technician, Sacaton
Dr. Daniel Brown, Psychologist, PIMC.
Marvin E. Buckley, Therapeutic Recreational Specialist, Owyhee
Mr. Ronald L. Willis, Psychologist, Stewart Indian High School.

Add To Tribal Programs

A contract was made with the U & O Tribal Council at Fort Duchesne for the services of a mental health technician. He is under the supervision of the MSW employed by the tribe and is participating in the DWTC-MIT Training program.

The Tribal Mental Health Clinic at Whiteriver is partially supported with $10,000 contract. Additional funds come from the Tribe, State and NIMH.

A $10,000 contract was negotiated with the Hopi Tribe to help support a Recovery House as part of their alcoholism program.

Marjorie E. Myren

MARJORIE E. MYREN
Chief, Mental Health Branch

MEM:vba

One factor in the smooth development of the programs for Mental Health in this Area seems to be the lack of rivalry between Mental Health staff and other program branches. The key role of Medical Social Workers is noted in the annual report. Observations and interviews during 1973 indicated that this was also characteristic of the attitudes of the Nursing Branch, particularly with reference to Public Health nursing, a relationship which should not be too surprising considering that this is the discipline to which Miss Myren belongs. However, the Maternal and Child Health, Field Health, and other programs also seemed to have excellent rapport at the local and Area level. If there was any problem it was in lack of staff and time to cover all the needs which each Branch could see as being of mutual concern. Planning and priority-setting seemed to be easily handled at the top echelons.

B. Daniel Brown, Ph.D. -- Special Consultant 1972-74

For Fiscal Year 1973 Dr. Daniel Brown was made available to the Mental Health Programs Branch to assist in planning and developing more localized training curricula. It was anticipated that at the end of the year he would become a part of the regular staff of the Research and Development Office in Tucson, where his special knowledge of Mental Health Programs would facilitate integration of these activities into the formal programs and information systems being developed by that office.

By the end of Fiscal 1974 there were twelve Mental Health Technicians and 11 professionals within the Phoenix IHS Mental Health Programs Branch. Their activities were supplemented by 5 contract consultants and 12

individuals or institutions classified by the Area Office as "other resources". These other resources included state hospitals in Arizona and Nevada, private and public mental health clinics, and individuals with special expertise in child psychiatry, detoxification, or inpatient care.

C. Summary of Policies and Problems

A statement prepared for the Area Director by the Chief of Mental Health Programs provides a general summary of the concerns and policies of the Mental Health Program Branch. It is therefore quoted here as a final general comment before proceeding to the description of individual programs.

> Mental health problems are considered to be some of the most significant and urgent health problems facing the Indian people today. Chief among these are alcoholism, suicide and juvenile delinquency. On one southwest reservation with a population of 4700, 2,401 persons above 15 years of age have been identified as drinkers and 4% or 94 persons as chronic alcoholics. Of the 2,401 drinkers, approximately 239 persons are considered pre-alcoholics and 29% or 708 mainly week-end drinkers, 333 are considered problem drinkers and slightly over 1,000 are considered potential problem drinkers.
>
> Over a six-month period in 1971 on this reservation, 677 individuals were arrested for disorderly conduct and intoxication. The total number of alcohol related arrests equals 3,428 from a reservation population of 4,700 -- 87% of all juvenile arrests were for intoxication. Although alcoholism is considered fourth among U.S. Public Health problems, on this reservation, it is the number one health problem.
>
> In the city of Phoenix last year of 17,000 arrests for intoxication 5,500 were Indian, although Indians probably account for less than 2% of the total population. During a six-month period in 1971 of the 44 deaths we had at Phoenix Indian Medical Center, 23 or more than one-half were due to alcoholic cirrhosis or chronic alcoholism.
>
> Suicides are also a significant problem on many reservations. In a study done on one of our small reservations the suicide rate was 100 per 100,000 population per year on an average or ten times the national average. What is distressing is that these suicides occured mostly among young ment with an average age of 22.

The high school drop out rate of Indian adolescents is also indicative of their problems. 42% (almost double the national average) drop out before completing high school.

The tribes recognize and are extremely concerned about the presence of mental and social illnesses on their reservation. Since our Mental Health Program began in 1967, we have had requests from all the tribes, for professional mental health consultants to assist them in developing comprehensive mental health programs. We are also training young Indian men and women as Mental Health Technicians. They are dedicated individuals who are eager to learn more effective ways to help their people. They are a motiviated group, the six who began training two years ago are still with the program even though they are expected to carry a workload on their reservation while earning their college credits. Our program approaches coincide with the identified needs of each tribe. On each reservation we offer direct patient care but possibly more time is spent on community activities. Preventive mental health programs for children and youth have been developed on several reservations. The results of these programs seem promising -- in one there has been an increase in the expectation of the Indian community for its children, the children self-image is improving and their attendance at school is becoming more regular. Suicide prevention workshops have been held for several tribal groups. As a result one tribe has developed their own suicide prevention program including a 24 hour "hot line". School mental health is being emphasized. Viable programs in which both students and staff participate have been developed at two of our off reservation boarding schools.

The roots of mental health problems on the reservation are many and complex. They are problems IHS can not solve alone. We are endeavoring to coordinate our efforts with other agencies, groups and the Indian people themselves to provide an environment that would promote mental health.

Public Health Service
Phoenix Indian Health Area Office
4110 North 16th Street
Phoenix, Arizona 85016

Keams Canyon, Arizona (68 miles north of Holbrook, Arizona)
Owyhee, Nevada (100 miles north of Elko, Nevada)
Parker, Arizona (Parker city limits)
Phoenix, Arizona (Phoenix city limits)
Sacaton, Arizona (43 miles southeast of Phoenix, Arizona)
San Carlos, Arizona (23 miles east of Globe, Arizona)
Schurz, Nevada (25 miles east of Yerington, Nevada)
Sells, Arizona (62 miles west of Tucson, Arizona)
Whiteriver, Arizona (39 miles south of Show Low, Arizona)
Winterhaven, California (2 miles west of Yuma, Arizona)

V. SERVICE UNIT PROGRAMS

In describing the Service Unit programs an introductory comment will attempt to give some indication of the cultural background of the tribe or tribes involved, and something of the economic activities significant in their lives at the present time. This will be followed by the summaries of program development as given in annual reports, supplemented by any observations made during actual visits or interviews with staff from these various programs.

A. Reno Field Office: Schurz Hospital and Stewart Indian School

The programs at this Service Unit are largely for the benefit of parts of the Shoshone and Paiute tribes on a reservation not far from Reno, often known to the general public for its association with Pyramid Lake. This group, which most probably also includes the Washoe remnants of a California tribe, were basically hunters, who took naturally to the use of the horse to extend their range. Only those near Reno had sufficient water to do any farming, rather than depending on gathering foods -- fruits, nuts, and vegetables -- in their travels.

With the coming of modern farming and irrigation techniques, the whole region around Reno has prospered, and the development of tourist attractions and recreation sites has also brought employment both on and off the reservation.

In his observations Dr. Elite describes the needs of this Service Unit as follows:

Mental health problems are becoming more evident in this area. It would appear that more patients are seen with psychoneurosis overlying minor organic illness. It is also of note that there is more effort to uncover these types of problems, and aid the patient in solving them. These patients are counseled and the more severe are referred to contract psychiatric consultants. This type of problem is particularly prevalent among the younger age groups and it would appear to be cultural identity related. At present psychotic patients and the severely retarded are handled primarily through consultants and comprise a minor portion of the mental health problems at Schurz.

A major problem for the service unit is the boarding school at Stewart. It is estimated that 70%-80% of the children at this school are in need of psychiatric care and counseling. A Mental Health Program was started in May 1966, following a joint BIA-DIH conference on mental health. A social work educator and group worker was assigned to the boarding school for six months. Due to lack of funds the program has temporarily been dropped. Contract psychiatric services are still utilized and proposals are currently in BIA headquarters for funding the mental health program.

One of the biggest problems faced by Schurz is alcoholism. In fiscal year 1967, about 50 chronic alcoholics were seen at Schurz and most of these were put on antabuse, plus receiving considerable counseling while hospitalized. Of the 50, only about 10 remained dry more than 4-6 weeks and only two or three remained dry for more than three months. At present the Nevada InterTribal Council is working on this problem with the University of Utah and other organizations (DIH Hospital at Schurz, Owyhee, A.A., etc.). It is hoped this will provide the impetus locally through the Tribal Health Committees for progress in finding solutions to this most difficult problem. It is also hoped that the InterTribal program will be well coordinated with the State of Nevada alcohol program so that various resources are utilized efficiently and effectively.

It is the philosophy of the service unit staff that with education as to what society expects, and to help the people understand their own problems, the major step will be along the educational line. The service unit plans to work with cooperating programs, i.e., Alcohol Program, State Mental Health Program, etc., as approached, or as the service unit approaches the other agencies for help. It is planned to utilize the psychiatric consultant at Schurz and Stewart for patients, both adult and children, at least quarterly or more often as need arises. This will be increased during F.Y. 1969 to a monthly psychiatric clinic.

In 1972 a psychologist, Dean Hoffman, Ph.D., was assigned to the Reno Field Office to serve as a mental health consultant to both the Schurz and Owyhee Service Units. An active alcoholism program had been developed, under

intertribal auspices, and was serving both on and off the reservation Indians. The program was based on AA themes, and also emphasized interagency as well as individual interdependence.

Ronald Willis, MS, also a psychologist, was assigned full time to the Stewart Indian High School, beginning in January 1972, and one Mental Health Technician, Priscilla Wachsmuth, worked out of the Reno Field Office. Although these sites look close on the map, they are all three 100 miles apart, and coordination of activities is difficult and minimal among them.

B. Owyhee Service Unit, Duck Valley Reservation

This reservation is quite extensive and overlaps into Idaho along the common border between that state and Nevada. The desert-like characteristics render this reservation more remote than many, since the nearest large cities are Elko, Nevada and Mountain Home, Idaho.

In 1968 Dr. Elite's summary of his observations of the needs of this reservation were as follows:

> The major mental health concern at Owyhee is alcoholism with its many ramifications of family disruption and auto accidents. Suicide is uncommon. Other forms of mental disturbance are seen occasionally. These are usually referred to contract psychiatrists in Boise, Idaho for evaluation. If hospitalization is indicated and cannot be successfully handled in the service unit hospital, arrangements are made either in Phoenix or directly with the Nevada State Hospital in Sparks, Nevada. There has been little use of the new State Mental Health Clinic in Elko. It is hoped that this resource will be utilized more fully in the future.
>
> A community service staff conference meets monthly to discuss and resolve mutual problems. The membership is composed of representation from the Tribe, DIH, State Health Department, BIA, Nevada and Idaho Welfare, Public Education, Agency Extension, and Law and Order. They have established a subcommittee (representatives from IIH, Welfare, Public School, Law and Order and Tribe) on problems of excessive drinking. An educational approach has been carried out concerning excessive drinking among Indian youth. The service unit gives medical treatment in the form of hospitalization and sedation for alcoholics with impending or active DT's. An A.A. program is currently in operation. A four-phase program is planned and partly in operation:

1. Medical treatment and detoxification (i.e., Librium).
2. Education on use and misuse of alcohol.
3. Antabuse program to be medically supervised.
4. Rehabilitation program for alcoholics in the program.
   This would include job finding and training, family services, etc.

This inter-agency approach led the Tribal Council to appoint a mental health committee, which included Council members, a Medicine Man, and student representation along with BIA and IHS consultants. This committee spent the year 1969-70 examining the potential suicide problem on the reservation and making recommendations for a preventive program. Their report of June 1970 is included here because of the richness of detail concerning both the Duck Valley Reservation and the program recommendations.

SUICIDE AMONG THE SHOSHONE-PAIUTE ON
THE DUCK VALLEY INDIAN RESERVATION

[A Survey Report, June, 1970, Prepared by The Tribal Mental Health Committee of the Duck Valley Indian Reservation.]

"Long range planning with Indians failed to include the need of human resource development. Lack of spiritual training of young Indian people has usurped the strength for better meeting the emotional problems of living." -- Alex Cleveland, Indian Medicine Man

In recent years there has been an intensification of interest in the problem of suicide among American Indian groups. In the past few years there have been several reports concerning the disproportionately high rate of suicide on some reservations compared to the national rate of suicide. Many theories have been advanced to explain this phenomenon including the stress of poverty, the breakdown of Native American culture, the changing role of men and women in American Indian culture, the result of alcoholism, a high rate of parental loss or surrogate child rearing, the disrupting effect of being sent away to boarding school at an early age. It is more probable that a complex of factors operate together on any given reservation to produce high or low rates of suicide. There is a need to understand the situation on each reservation. One needs to know what is unique about a given tribal group at a given point in time that may be playing a role in the problem of individual suicide.

In every suicide there are both personal and socio-cultural factors which have combined to lead the individual to the conclusion that his life is no longer worth pursuing. An understanding of these factors is essential if one is going to develop a rational approach to suicide prevention.

This report concentrates on providing a description of the Duck Valley Indian Reservation and the people who live there. The nature and extent of the problem of suicide on the Reservation is detailed and finally some recommendations and conclusions are presented.

A concerned group from the Reservation and the Tribal Council formed a Mental Health Committee especially concerned with the problem of suicide.

How the Committee was Formed

The Tribal Council members of the Shoshone-Paiute Business Council became especially concerned when three young male suicides occurred a few weeks apart. This was a precipitating event in light of the high rate of suicides in the past. The Council adopted a resolution for the study and prevention of suicides on the Duck Valley Reservation. A Tribal Mental Health Committee was selected from all age groups representing all areas of the Reservation. This Committee included the Indian Medicine Man.

The Chairman talked with the various people mentioned by the Council to serve on such a Committee. Ten people were selected and seven responded. The Committee first met on January, 1970, to discuss goals, procedure, and to select their leaders such as a chairman, vice-chairman, secretary and consultants. Various meetings followed sometimes formally and sometimes over steak and fish fries. The Tribal Council Chairman of two Reservations, Fort Hall and Duck Valley, arranged a visit in June or July to the Fort Hall Reservation Mental Health "Half Way House."

Dr. James Barter, Deputy Director of the Sacramento Mental Health Clinic was chosen as the psychiatric consultant to help the Committee with organizational methods. He was chosen because of his rapport with Indian groups in suicidal conference studies and because of his background experience in work with the Wyoming Shoshone Indian suicidal studies and his anthropological background.

How Study was Formed

The Committee got a contract from the Public Health Service to conduct a study of suicide, and decided to look at every suicide in recent years. The Committee members made up the list with the help of relatives, hos-

pital and Bureau of Indian Affairs records. They devised a form to gather basic demographic and other information about the suicides. Each member of the Committee took responsibility for interviewing close relatives about each suicide and filled out the form based on this interview. Every available source of information was used to check accuracy of data.

THE DUCK VALLEY RESERVATION: A BRIEF SKETCH

A. HISTORY

The State of Nevada, or what is commonly referred to as the Great Basin, contains three major groups of Indians, viz., the Washoe Indians, the Paiute (Northern and Southern) Indians, and the Shoshone Indians. Generally, the Washoe Indians occupy the extreme West-Central part of the State, the Northern Paiute occupy the Western half of the State, the Shoshone occupy the Eastern half and the Southern Paiute occupy the Southern tip of the State.

The people of the Duck Valley Reservation are basically a mixture of Shoshone and Paiute with there being several such groups of these two tribes represented on the Reservation. Early immigrants to the Reservation included Shoshones from the Owyhee Canyon area and from the Ruby Valley, Clover Valley Indians, both Paiute and Shoshone from near Golconda, and Paiutes from the Malheur Reservation in Oregon. The latter group of Paiutes were originally from Idaho but were moved to Yakima, Washington and then to the Malheur Reservation in Oregon by the federal government as punishment for sympathizing with the Bannock Indians of Idaho in what was termed the Bannock War of 1878.

There were three major allocations of land made to the Duck Valley Reservation, in the years 1877, 1886, and 1910. The first was with creation of the Reservation by Executive Order of President Rutherford B. Hayes in 1877. Originally the land had not been occupied by Indian groups but had been settled by White ranchers with only possessory rights. By 1877 the situation among Indians in the area had become rather bad primarily due to the lack of available water and good land, much of this land having been purchased by White ranchers from, the government lands on which the Indians lived and farmed. The Government had for many years promised to set aside prime lands as a reserve, such as the lands of the Ruby Valley, but never kept their promises and eventually sold off these lands to White farmers and ranchers. This in turn had a very demoralizing and disenchanting effect on the Indian people of the area and spurred on efforts by Indian leaders to set aside the Duck Valley area as a reservation.

Soon after the creation of the Duck Valley Reservation a large number of Indians moved to the Reservation from a nearby reservation called the Carlin Farms that had also been created in 1877. Although the reports of the Indian agents on this Reservation were filled with stories of great success, the fact was that the Reservation had deteriorated, largely because of mistreatment of the Indians by White soldiers.

In 1878 the Bannock War raged immediately to the North of the Duck Valley Reservation between the Indians around Fort Hall, Idaho, and White ranchers and authorities. The Bannock desperately tried to recruit Shoshones and Paiutes in the area to join them in their fight against the Whites, but to no avail. Indeed, many of the Duck Valley Indians assisted the White man in the war by acting as scouts and reporters and by keeping lookout and giving ranchers warning. The reasons for this attitude by the Duck Valley Indians were (1) the Bannocks were as opposed to The Duck Valley Indians as they were to the White man, and (2) the Duck Valley Indians felt an obligation to keep the terms of the peace treaty they had signed with the White man.

Another threat to people of the Reservation occurred in 1884 when Whites began to realize the potential of profits from the beautiful lands of the Duck Valley Reservation. Pressure by Whites built up to move the Indians to lands around Fort Hall but an 1884 decision by the Department of Indian Affairs ensured that the Indians would maintain their lands in Duck Valley. In May of 1886 an Executive Order by President Grover Cleveland set aside more land in Idaho Territory to be included in the Duck Valley Reservation. The land was set aside primarily for the Paddy Cap Paiutes (Paddy Cap was the leader) that were being allowed to return to their native lands from the Malheur Reservation. Those Paiutes settled in the Idaho portion of the Reservation and started a cultural pattern that can be discerned to some degree even today, viz., that the Idaho lands consist mostly of Paiutes while the Nevada lands consist mostly of Shoshones.

The third and last addition to the Duck Valley Reservation was made in 1910 by President Taft's Executive Order reserving certain lands in the State of Idaho.

In the early years of the Reservation the Government supplied rations to the Indians which the Indians augmented with native foods of their own, and the Government supplied a small sum of money to certain of the Indians to construct crude cabins. Two flour mills were constructed on the Reservation by the Department of Indian Affairs but proved to be the first victims of what was to plague the Reservation to this day, viz., its isolation from major distribution centers.

A police force was authorized for the Reservation in 1879 and in 1911 the first church, a Presbyterian Church, was established. To this day the Presbyterian Church is the largest Church on the Reservation in terms of size of congregation, with there also being a Church of Latter Day Saints and an Assembly of God Church.

The Government built two boarding schools on the Reservation, one in 1884 and one in 1910. Both were abandoned by 1911. The Government subsequently built and operated three day schools, one in Owyhee, one in Miller Creek and one in Chinatown, which operated until 1931 when the Owyhee school classes were added to the school in 1946 and a high school addition was constructed in 1955. In 1956 the local school district at Owyhee consolidated with the Elko County School District, an arrangement that is utilized to this day.

The U.S. Bureau of Reclamation completed the Wildhorse Reservoir, immediately Southeast of the Reservation, in 1938 that stored waters of the Owyhee and tributary rivers for irrigation purposes on the Reservation. The Reservoir also provides fishing and boating recreation for people of the Reservation as well as for people in the nearby areas in Nevada and Idaho. A new and larger dam has recently been completed taking the place of the original Wildhorse Dam.

The Reservation today consists of almost 290,000 acres of land, and is divided almost equally between the States of Nevada and Idaho. The focal point of the Reservation is the town of Owyhee located in Nevada approximately 100 miles North of Elko and housing most of the major facilities and services on the Reservation, as well as the largest concentration of people.

B. THE PEOPLE, A GENERAL PROFILE

As mentioned, the people of the Duck Valley Reservation are basically of two major tribes, Paiutes and Shoshones, but are descendants of several subgroups within these tribes. Although the greatest concentration of people is at Owyhee, the settlement pattern of the Reservation is basically scattered and rural. At present there are approximately 1350 enrolled members of the Shoshone and Paiute tribes with approximately 175 non-Indians living on the Reservation. Although the population has been rather stable through the years, total population figures will vary at seasonal employment among the people that are off the Reservation.

Reservation development and employment prospects could further stablize the growth pattern. A very high percentage of the tribes speak and understand English well. Understanding future population prospects is important to the planning efforts on the Reservation.

The following table shows a population profile of the people of the Duck Valley Reservation:

DUCK VALLEY RESERVATION
AGE CHARACTERISTICS COMPARED TO NEVADA

Age Group	Duck Valley Indians Number Male	Female	Total	Percent Total	Nevada Percent
Under 14	163	173	336	35%	30.6%
14-17	49	42	91	10%	5.7%
18-24	70	50	120	12%	4.1%
25-34	79	70	149	15%	14.1%
35-44	44	32	76	8%	15.2%
45-64	61	65	126	13%	20.5%
65 and over	32	34	66	7%	9.8%
TOTAL	498	466	964	100%	100 %

SOURCE: U.S. Public Health Service, Demographic Survey of Duck Valley Reservation, 1970.

As can easily be seen by comparing age groups of the Reservation with State averages, the Reservation has an abnormally young population profile. As indicated in the above Public Health Service data, there are 964 persons residing on the Reservation as of January, 1970. As mentioned, this figure varies with the season. Three different estimates in 1965-1966 derived figures ranging from 799 to 990. When the 150 non-Indians residing on the Reservation are added to the 964 figure for 1970, there is a grand total of 1140 persons residing on the Reservation. The above figures also indicate a problem that is prevalent not only on the Duck Valley Reservation but on numerous reservations, especially the more rural ones. This is the problem of out-migration of younger people on the Reservation, primarily due to the lack of employment opportunities on the Reservation.

Suicides on the Duck Valley Reservation

In recent times there have been 25 suicides on the Duck Valley Indian Reservation. This section of the report details some of the results of the study conducted by the Mental Health Committee.

The known suicides that could be remembered by various members of the Committee dated back to 1938. However, the majority of the suicides have occurred since 1950, there being none in the decade from 1940 to 1949. For each five year period from 1950 on there has been approximately an equal number of suicides. The greatest number of suicides in any given

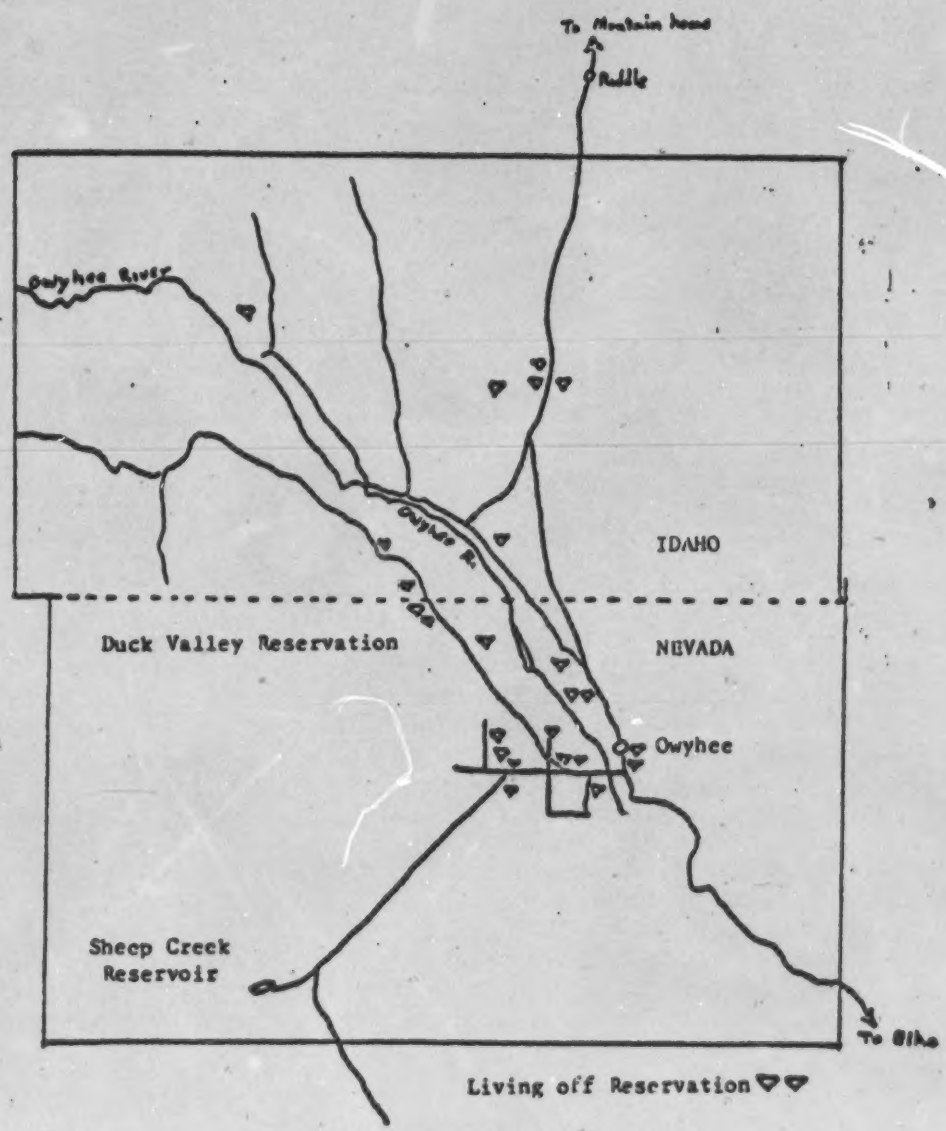


Figure 1. Place of Residence of Suicides on the Duck Valley Reservation.

year has been three in 1955 and 1969. There have been only four years since 1940 when there was no suicide. Thus the rate has been surprisingly stable for the last 20 years. That is there is no evidence of an increasing rate of suicide in the past five years.

Table 1. Number of Suicides in Each Five Year Period from 1935 to 1969.

1935-1939	1	1955-1959	7
1940-1944	0	1960-1964	6
1945-1949	0	1965-1969	5
1950-1954	6	1970-	1

Some contributory factors may be the repeal of the Indian Prohibition Act of August, 1953, tribal rivalry, prosperity due to increased cattle prices, the Korean War lasting from 1950 to 1954, World War II veterans adjustment to reservation life and improvement of the highway through the reservation to neighboring towns.

As of January, 1970, there were 964 Indians and 150 non-Indians residing on the Reservation for a total population of 1114. The total population on the Reservation has been rather stable throughout the years but fluctuates somewhat due to seasonal employment. The average suicide rate per year then is roughly one per thousand or ten times the national average.

Figure 1 (facing) is a sketch map of the Duck Valley Reservation on which the place of residence of each of the completed suicides is indicated by means of an inverted triangle. This distribution roughly follows the pattern of population density on the Reservation and there is no striking pattern to indicate that one or another area of the Reservation has a disproportionate number of suicides. A total of seven suicides occurred off Reservation. Two individuals were living off the Reservation at the time of suicide, one was working on a ranch and the other was in the Air Force in California. The other five were technically living on the Reservation, and four of these suicides occurred while the individual was incarcerated in jail.

Most of the suicides occurred either inside a house (10) or just outside the home (8). Three of the suicides occurred in a car in a remote place on the Reservation. One in an Air Force service barracks. Twelve were veterans.

As has been reported in other studies of suicide in American Indian groups, most of the individuals who completed suicide were young males. Of the 26 completed suicides on the Duck Valley Reservation, 24 were males and 2 females. The age range was from 16 to 64, but almost 85% were under the age of 34 and 61% were under the age of 24.

Table 2 shows the number of individuals in each age group as well as the percentage and cumulative percentage for this study. Half of the individuals in the study were in the age range 19 through 23. This age group represents only about 12% of the total population of the Reservation, but accounts for 50% of the suicides.

Table 2. Number of Completed Suicides by Age Group on the Duck Valley Indian Reservation.

Age Group (years)	Number of Individuals	Percent in Age Group	Cumulative Percentage
15 - 19	4	15.4	15.4
20 - 24*	12	46.1	61.5
25 - 29	5	19.2	80.7
30 - 34	1	3.8	84.5
35 - 39	1	3.8	88.4
40 - 44	2	7.7	96.4
64**	1	3.8	99.9

*This Group Contains One Woman Age 22
**Woman Age 64.

The average age at death for the sample as a whole was 26.2 years. With the ages of the two women excluded, the average age at death for the males was 24.8 years. If one looks at the tribal affiliation of the suicide victim one sees that there are more Paiutes (14) than Shoshone-Paiute (9) than Shoshone (3). Whereas on the Reservation there are proportionately more Shoshone-Paiute than Shoshone with the Paiute being the smallest group. There is a difference in age at death for these three groups as well, although it is perhaps not pertinent to emphasize these differences because of the small size of each of the groups. The average age at death of Paiute male suicides was 22.5 years, for the Shoshone-Paiute males 26.9 and for the Shoshone males 28.0 years.

More than half of the suicides (16) occurred during the cold weather months (November through April). Eight suicides occurred during the warm months of May through October. April was the month of the greatest number of suicides (5) with November (4) and January (4) close behind. Unemployment is between 80 and 90% during the winter months.

The suicides not associated with alcohol (males) were married. Most of the suicide victims had used alcohol just prior to the suicide. Nineteen of the suicides were felt to be associated with the use of alcohol, four were believed not to be associated with alcohol use and the data were not known for the other three.

In terms of the method of suicide, there is a heavy preponderance of gunshot wounds. Eighteen of the 26 suicides were completed with guns. This is probably not unexpected in a hunting community where almost every family has one or more guns. There were six deaths from hanging, and four of these occurred in jail. Both women injested poisons. One single car, single driver accident is included as a suicide because almost everyone considered it to be such.

In contrast with the study of suicide on the Fort Hall Reservation as reported by Dizman, et. al, almost all of the suicide victims at Duck Valley were raised by their parents and did not have other principal caretakers. That is 2/26 lived their childhood with their parents, 4/26 were raised by relatives and 1/26 had multiple caretakers. In this regard it is also interesting that only two individuals spent time in boarding schools. 19 out of 26 were dropouts (did not finish high school).

RECOMMENDATIONS

The following recommendations have been discussed among the Tribal Mental Health Committee Members:

A. Improving the Indian Image.

1. i.e., helping people feel good about being Indian.
2. Tribal Cultural Center.

B. Orientation

All Agency leaders and employees should respect Indian values, employees should have some orientation using the Tribal Council and Tribal Mental Health Committee as its resource.

C. Tribal Mental Health Committee and other mental health resources work together to prevent suicide (Public Health Agencies, State Health Agencies and other voluntary agencies).

D. Resource
Someone to confide in

1. Dr. Lamar Hayrend, Public Health Indian Service Psychiatrist.
2. Alex Cleveland, Indian Medicine Man, enhance spiritual strengths in time of need.
3. Tribal Mental Health Committee continue to be available to potential suicidals.

E. Set up a suicide register at the Public Health Hospital.

F. Place more emphasis on vocational training programs.

G. Provide more employment.

Estimated Annual Cost and Proposed Staffing

Meeting per year	$1,200.00
Orientation - two weeks	2,500.00
Medicine Man Consultant	300.00
Psychiatric Consultant	2,500.00
Records Secretary, Mental Health Case Aid	6,500.00
Office Space Per Year	600.00
Travel, Training and Transportation	1,000.00
Miscellaneous Per Year	600.00
Telephone	500.00
Supplies, Locked Filing Cabinet, etc.	500.00

Respectfully submitted

TRIBAL MENTAL HEALTH COMMITTEE
Arthur T. Manning, Chairman

"Our people learn best when knowledge is served from warm hands."

-- Alex Cleveland
Indian Medicine Man

This report is the earliest official request found in this Area for IHS payment to a Medicine Man as a Mental Health consultant. With the addition of a Mental Health Technician in 1971 and a full-time professional consultant at the Mater's level, many avenues of approach were explored.. A full-time Recreational Therapist was secured to develop a youth program of a preventive orientation, as well as to provide therapeutic involvement of teenagers who are having problems resolving their identities and dealing with the cultural stress not only of Indian life, but of a rapidly changing major culture as well. This step was taken as a result of planning by the Shoshone-Paiute Health Committee as summarized in the following memorandum.

> The original objective was to plan and implement a therapeutic recreation program for children and youth to promote good mental health and prevent alcoholism for those who are at a high risk of developing mental illness.
>
> During FY 73, the first pilot year of the program, we identified 80 children from grades 4 to 12 through the Tennessee Self-concept and the Piers-Harris tests and evaluations of school staff personnel, mental health staff, etc., who are at high risk of developing mental illness.
>
> Our target group this year will be these 80 children and in addition, any other students who become identified as being high risk this year, although all children will be included in all aspects of the program.
>
> This year the program will be coordinated more with the school. The school counselors and teachers will cooperate and also work with the same high risk children. Each high risk child will be evaluated by the recreational therapy staff, mental health staff and consultants, and school counselors, and an individual treatment modality planned for each child. Examples of these are, individual counseling, group sessions, planned recreational activities to meet the child's needs, positive role modeling, etc.
>
> The tribe will employ two recreational aides, one male and one female, who will work with the Recreational Therapist and the mental health committee to assist in developing and implementing the program. Both aides will be chosen for their interest in youth and will receive continuous in-service training in child mental health.

The program this year will include more special interest activities to increase and maintain the interest of the children in the program. The recreational therapist, aides, and mental health committee will work with other persons involved in other recreation programs in locating and scheduling persons to conduct these special programs. Examples of this would be oil and water color painting, arrowhead making, lapidary (stone cutting and polishing) and fashioning articles of polished stones, and others requiring special knowledge and skills. Special interest films will also be obtained and shown, with the children determining largely the selections.

A wider range of activities and arts and crafts will be available so that each child will be more able to find one in which he will feel comfortable and secure. Hopefully these activities and arts and crafts will result in a carry-over of interests into the outside world.

More Indian culture and heritage oriented activities will be presented which will be designed to elevate the self-image, self-confidence, and self-pride of Indian children. This will be done primarily with the help of volunteers (well qualified) which have been found and have expressed a genuine willingness to help.

An effort will continuously be made to involve parents in the program. This will be done through personal contacts and community educational meetings to increase awareness, interest, and insight into the needs of the children. More field trips, on and off the reservation, will be organized for the children for cultural and educational enrichment. and to expose them to future opportunities in education and vocations.

Psychiatric consultation is provided on a contract basis and the psychologist at Reno is also available for active program consultation. Eleanor Jones has been active as a Mental Health Technician since January 1971. This staff, together with the services provided by inter-tribal agencies and the IHS hospital, form the nucleus of a comprehensive local program with a somewhat different flavor than many, due to the close interest and participation of the Tribal Council.

C. Fort Duchesne, Utah

The Ute tribes have three reservations that overlap into Utah, but this is the only one under the Phoenix Area. Tensions between Indians of the plains culture and the white settlers typifies the Ute tribes as late as 1879. The Uintah Band is settled in northeastern Utah, in the slopes of the Rocky Mountains, and fairly well off the beaten track of most tourists. However, vacationers, lumbering interests, and some potential skiing sites prevent them from being completely isolated from outside contact.

The involvement of the tribe in developing local resources is evident in Dr. Elite's report on his visits during the first years of IHS Mental Health Program development.

> By cooperative agreement with Uintah County Health Department, BIA and DIH, mental health services to the Indian beneficiaries were expanded. (Uintah County paid for transportation and professional fees for services provided in Vernal; BIA provided office space, and DIH paid $85 monthly for professional fees for services provided at Ft. Duchesne.) One day a month visits were provided by a psychiatrist from Salt Lake City. Unfortunately, his services are no longer available. This monthly fee is now being used to pay for psychological referral and treatment of Indian school children. Uintah County and Ft. Duchesne have negotiated for a mental health center in Vernal to be staffed primarily by State mental health personnel which would include monthly visits by Dr. Washburn of the State Hospital who heads up Region III of State of Utah mental health setup.
>
> A few mental retardates receive services of the Utah State Crippled Children's Program and secure routine medical services from the service unit.
>
> The Alcoholism Program has moved forward considerably this year. It is fairly clear from service unit staff and BIA that alcoholism and its related problems are the No. 1 health problem faced on the reservation. A Tribal Alcoholism Committee has been formed to organize a comprehensive alcoholism program in cooperation with the Basin Alcoholism Committee, a non-Indian county group. The Tribal Alcoholism Committee includes the Service Unit Director, Tribal Judge, State Welfare representative, member of clergy, and three members from each of the three Indian communities represented by the Uintah Ouray Indian Agency.

Workshops have been conducted by the Utah School on Alcohol Studies. Since that time, both Indian and non-Indian alcohol committees have decided to pool resources and unify under the name of The Uintah Basin Committee on Alcoholism. It is hoped by combining forces that the group can apply to State of Utah for the establishment of a regional comprehensive alcohol treatment and rehabilitation center in the Uintah County. This would be a great step forward for both the Indian and non-Indian communities, not only for the obvious benefits for the alcohlic and his family but also for the Indian and non-Indian communities who would work hand-in-hand with each other in a cooperative effort which could only lead to greater mutual understanding.

Dr. Church, current SUD, cited suicide and family disintegration as occurring in greater frequency. He estimates that, if one pools together the money spent on treatment of mental disturbance plus conditions resulting from mental health dysfunction, such as injuries from fights and exposure as results of being intoxicated, the category of mental health by far outweighs any disease category in terms of morbidity and mortality.

Perhaps because of distance, no further reports on this program were available. Since Fort Duchesne's Mental Health program is tribally operated rather than IHS staffed, some idea of how it came into being and how it well it is functioning would be of great interest.

D. Hopi

Along the Mogollon Rim, an escarpment that crosses much of central Arizona and New Mexico, are found huge caves sheltering the ruins of a cliff-dwelling, pueblo-like population. These ruins suggest that the ancestral homes of pueblo-dwelling people were far more extensively distributed than the present Pueblo populations. The only true Pueblo group in Arizona are the Hopi, whose reservation lies in the west-central portion of the Navajo Reservation. Most of the Hopi villages are located for safety's sake along the tops of the First, Second and Third Mesas. Oraibi competes with Isleta and Taos in New Mexico as one of the oldest towns in the whole of the U.S. still in its original site. The other villages were established within recorded history when expanding Hopi populations responded to a need to protect themselves against warfaring neighbors, especially the Navajo and Apache.

Unlike most other Pueblo groups the five Hopi-speaking villages located on or near the three mesas have managed to form a Hopi Tribal Council and function as a single unit in relation to federal programs and officials. This does not mean that there are not distinctive characteristics in each village, or that local autonomy in matters of religious and civil governance is not handled by individual villages. At some level of abstraction the Hopi have managed a kind of city-state parallel in their political organization which makes it possible to function both as separate pueblos and as a unified group, depending on what is appropriate at a given time and in a particular situation.

Perhaps one reason that they have been so successful lies in their history of comparative freedom from harrassment by a succession of white, non-Indian attempts at governance. Spanish efforts to colonize and convert the Hopi were ineffective, especially since the Hopi joined the New Mexico Pueblos in Pope's Revolt in 1680 and succeeded in exterminating all the missionaries. Not until the US took possession of these lands from Mexico were the Hopi troubled by non-Indian contacts. For these reasons their mythology and religious customs have survived in greater detail and complexity than most Indian cultures, and are in some ways better understood because of their coherent wholeness. There is a complete annual cycle of observances, most of which take place in the Kivas, or special underground meeting places, away from the contaminating eyes and curious ears of outsiders. However, nearly every such holiday has its public portion, usually a closing observance, and some of these are well known (such as the so-

called "Snake Dance") since tourists are not only tolerated but have been welcomed as participating observers.

One amusing anecdote is told of this observance, and it illustrates the fact that the Hopi not only believe in the unity of all living things -- including non-Indian tourists -- but also perhaps suggests the economic importance of tourist trade to the villages. The Snake Dance occurs during the summer season when vacationers are willing to spend money on food, souvenirs and crafts articles, as well as on a modest admission fee to satisfy their curiosity about exotic performances and costumes. However, the growing militant mood of a number of pan-Indian groups has emphasized the importance of returning to old ways as a private right. One of these groups, an AIM chapter mainly of youthful non-Hopi, decided to make a demonstration by stopping tourists from entering the pueblo from the main highway. Seeing what was happening the older Hopi women snatched brooms and rakes and dashed down off the mesa and routed the militant demonstrators, to the great amusement of all spectators. The combined ridicule and humiliation of being chased by Indian women caused the group to look elsewhere to begin their purification of old rituals from white contamination.

What they perhaps did not realize was that the Hopi have plenty of privacy for other times, and choose to share this blessing with the curious, along with garnering its small but appreciated cash income. The role of the women is not accidental, for the Hopi are organized in a matriarchy where each person belongs to his mother's clan, and where the women own

the household and its contents in their own right. This is offset by the non-familial organization of the religious societies, which are of a single sex, and where men's societies outnumber the ones for women and girls. Thus, some balance of equal rights is part of the working relationships of Hopi life, and each sex takes its own responsibility for appropriate actions as they see occasion for them.

Even more familiar to the general public than the famous Snake Dance are the Kachina dolls that are sold for collections and as souvenirs. The Hopi themselves focus much on the observance of the Kachina's visit each winter. According to Hopi mythology, the Kachina are ancient spirits who once dwelt among men, but left either because their teachings were neglected or in death in battle with Hopi enemies. However, they left behind their clothing and the memory of their ways, so that each year they can be reincarnated for several observances. The highly decorative and diversified costumes are made by men and boys, and gifts of baskets, dolls, and other objects are accumulated at the appropriate times for the Kachinas to distribute.

It is estimated that about 500 to 1000 persons take the roles of Kachina in these re-enactments annually -- admonishing a few bad children and rewarding many for good behavior. The Kachina remain available, teaching and enjoying the festivities during the winter months. With that many personalities to identify, each of whose special characteristics need to be remembered, the presentation of doll-like images so that the children can memorize the Kachinas of special interest to them and their families has always been a custom. Some of these figures, elaborately carved and dressed, are sold in art galleries or collected by museums. Less expensive ones are frequently found in tourist

stores. There is a cultural center operated by the Hopi themselves which has Kachina Dolls, baskets, weaving and other crafts for sale.

The Hopi language is distinctive, but in one of the Hopi pueblos Tigua or Tewa, a language of several New Mexico pueblos is spoken. This suggests a migration took place at some time, and there are some stories about strangers being incorporated into the Hopi to substantiate this. The Hopi are also found in small but significant numbers in the Colorado River country, mainly on the California side of the Arizona-California border. This migration can be dated as a resolution of an internal dispute over whether to be friendly or unfriendly to the United States in the 1850-70 period, and perhaps significantly the descendent group that migrated West seems to contain a preponderance of Tewa speaking people. Some family ties and certainly many cultural ties keep these wandering groups in touch with one another, but the home and basic Hopi orientation involves their present location.

This tie to specific locality, which is a trait shared widely among many Indian tribes, must have been poorly understood in early stages of US-Indian relationships. While the First, Second, and Third Mesas are definitely Hopi owned, there is a large tract of land stretching to the north and west of these mesas that was designated to be shared by the Hopi and Navajo. As population has increased in both tribes, and as the need for an economic land-base with its mineral and grazing rights has become more important to the survival of each tribe, there is deep bitterness over the possible loss that will be involved as attempts are made to establish boundaries and decide exactly what land belongs to whom. Feelings run deep, and tempers flare out, so that it

will take the wisdom of Solomon to arrive at a final solution to this problem which clouds the horizon for Hopi and Navajo alike. Some of the stresses and strains no doubt will be reflected in the mental health problems addressed by the IHS staff, although little of this is reflected in the official Mental Health Programs reports.

It is at least in part because of the tensions over this land dispute that the IHS serves the Hopi Reservation from the Phoenix Area Office, even though Keams Canyon is closer geographically to many of the Navajo Service Units. In his initial visits Dr. Elite made the following observations about Mental Health activities among the Hopi.

> Mental health programing is beginning to take more positive form with the introduction of a skilled DIH social worker. Referrals are made through the social worker to Phoenix or to the nearby Navajo Mental Health team in Window Rock. Explorations are being made into the feasibility of utilizing State mental health services as they develop in such communities as Winslow and Flagstaff. Conferences with Reservation school personnel concerning school problems are held monthly (between public health nursing and school staff).
>
> The pilot program started last year to aid mentally retarded children is still in operation. This was initiated as a cooperative program with BIA, PHS, State Department of Special Education and the Indian Education Department of Arizona State Public Schools. The purpose is to evaluate the need for special education classes on the Hopi Reservation. The children selected are slow learners, those that had received social promotion and those that seem to be having emotional problems. Teachers have been asked to write their observation of the child involved; a physical examination is done and social history written about the child and his family. Several workshops have been held and plans are being made for special education classes this year. Follow-up services are being given to children with special problems, emotional and learning problems.
>
> In terms of an alcohol program, the Keams Canyon Service Unit continues to participate in the ONEO Alcoholism Treatment program which deals primarily with Navajo alcoholics. The patients included in this program are followed by a Navajo community worker from the ONEO Project. Most of the community workers were formerly problem drinkers and also recieve medical supervision from DIH medical staff. In terms of the Hopi beneficiaries on the reservation a program of antabuse and education is being initiated, with the help of the local judiciary, to aid the chronic drinker.

Dr. Anders made some of his flying consultations to Keams Canyon, and assisted with the selection of Percy Pavatea as one of the Mental Health Technicians trained in 1971. Dr. Marian Zonnis, M.D., who is on the Window Rock staff (Navajo Area Office) makes regular weekly visits to Keams Canyon. There does not seem to be any real conflict being engendered by this arrangement. As a matter of fact, Mr. Pavatea has also supplemented his training by participating in many of the inservice sessions offered to Navajo Mental Health Workers, and he seems to be well respected by both tribes. It is ironic to note that this in many ways ties the Hopi Mental Health Program closely with the Navajo Area, even though administrative consultation visits from the Phoenix Area Chief are made periodically. This duality of relationships may be realistic in terms of the geographic and political position of the Hopi Reservation. However, it is not clear whether or not it facilitates IHS effectiveness.

At the present time the activities and demands for service are sufficiently numerous and complex that the Hopi are requesting the establishment of a full-time professional person by the Mental Health Programs Branch. This can probably be taken at one level to indicate there is steady progress and some satisfaction with services presently received. At another level it may be symptomatic of dissatisfaction with the diffusion of authority and continuity that derives from the actual involvement of two IHS Area staffs, each with different orientations and administrative support systems.

E. Apache

The Apache as a tribal type are well known to most movie watchers, whether from Saturday matinees, late night TV or other vantage points. Among the Hopi, Navajo and Pueblo tribes of the Southwest they had a reputation as raiding Indians, and were also well known to the Plains Indians whom they resemble in some characteristics. In point of historical fact the Apache seem to be most similar in language structure and belief systems to the Navajo. Apache spoken as a language can be understood by the Navajo and equally Navajo is intelligible, although not exactly familiar sounding to the Apache. Anthropologists trace the appearance of both Apache and Navajo in the southwestern part of what is now the U.S. to about 1000 AD -- and seem fairly certain that they were the result of a migration from Canadian and Alaskan regions.

The Zuni word for enemy -- "apache" -- was nearly universally applied to this Athabascan type of raider, whose economy was based upon hunting and stealing from farming and other more sedentary or thrifty communities. The horse was a great boon to groups organized on this principle of a fast, terrorizing attack and equally fast departure, carrying as much as possible along as loot. However, unlike most other Indians using the horse, this seems to have accentuated, rather than changed the ways of life of the Apache as a people. Cochise, Geronimo, Victorio, and other leaders are famous for extending the raiding way of life well into days of U.S. settlement.

The Apache were organized into rather large bands, with a clan structure descending matrilinearly, as in the Navajo and Hopi. Brush arbors and other dwellings were constructed, usually in naturally defended places. Traders and others who knew them and lived within the same terrain usually comment on their wilyness, keeness in planning and solving problems, and intense

loyalty to those to whom they gave any respect and trust. Skill in survival, in taming and using animals, and in wresting a living from what was apparently barren land are also mentioned.

The colorful dances of the Apache are not so well known away from the areas in which they live. One of the few which has become rather popular in public meetings and intertribal gatherings is the dancing usually performed at the time of initiation of pubertal girls. In this dance, men, masked by black hoods, not only perform an intricate formal dance, but also engage in chasing and "capturing" the girls or women spectators, and much satirizing of the personalities of the community and audience.

There are about 12,000 Apache in Arizona, roughly equally divided between the two reservations: White River and San Carlos, in the eastern central mountains. At one time an effort was made to confine all Apache to the San Carlos area, but natural divisions within the group of bands and the size of the population led to the formation of the two reservations. The Indian Health Service maintains a hospital and a full range of health services on each reservation. Their separate Mental Health Programs are described below.

1. White Mountain Apache

a. Description of the Reservation

The White Mountain Apache have a large reservation in the east central ranges of the Rockies as they descend into Arizona. The Mogollon Rim, a sheer drop off from a plateau that extends rougly east-to-west across Arizona and New Mexico, is in the northern stretches of the White River Reservation The southern boundary is formed by the White River which, after it meets the Black River, forms the Salt River. The Salt River in this part of the state flows through Deep Canyon and provides on a smaller scale scenery as spectacular as that of the

Grand Canyon of the Colorado. At its northern edge the reservation is in a region being developed as a ski resort and summer cottage recreational area. Scattered over the reservation are a great many lakes and both fishing and hunting for elk, deer, bear and other game are managed by the tribe. The forest cover of the mountains, mostly pine, provides lumber for a large sawmill at the town of Whiteriver, which is tribal headquarters.

b. Mental Health Program -- Northern Arizona Guidance Clinics

The development of a comprehensive Mental Health Center for northern Arizona was made possible by organizing a series of smaller units, each of which while affiliated, also has some local funding and responsibilities. The Apache Tribal Guidance Clinic at Whiteriver under the direction of Donald Ostendorf, a Clinical Social Worker, is one of these, with multiple funding sources. Some of its funds come from the Whiteriver Apache Tribal Council, some from IHS, some from various other federal sources for particular projects, and the bulk of the funding through the Northern Arizona Comprehensive Guidance Clinics and Mental Health Center.

This multiple funding base results in a total budget of around $80,000.00 per year, and involves a staff of three professional persons, and various numbers of clerical staff and Community Mental Health Aides. The Director has a social work background and had had experience at two other IHS programs in other Areas before taking this position in 1971. A psychiatric nurse and a special education teacher complete the professional team. IHS not only contributes to this budget but also encourages close working relationships with the Medical Social Worker and Mental Health Workers attached to the hospital staff also located in White River.

The Mental Health Workers of the Apache Tribal Guidance Clinic have generally had similar training to that of the CHR's at Desert Willow Training Center, and serve as case finders, translators and transportation providers. Their pay scale, being independent of IHS, is not as high as similarly titled IHS staff in other Areas, and they have not generally had the continuous training provided through the Social Work Associate Program or other advanced work to develop them into clinicians.

The White River Apache Guidance Clinic has undertaken a number of community-related projects in addition to its clinical functions. One of these, originally designed to help remove the stigma associated with seeking help in a mental health facility, was a women's project in reviving crafts skills. Experienced needleworkers, and bead workers were invited to hold classes at the Guidance Center, which is based in a typical house in the community. Supplies, particularly beads, were bought wholesale and made available at cost, a considerable savings for craftswomen over the trading post prices. At regular weekly sessions, women and their children gathered to make medallions, sew clothing and dolls, or other articles for themselves, their families or for sale.

During these sessions talk flows freely, and members of the clinic staff are available for counseling individually or as contributors to the group. Needs of the community, as well as individual and family problems can be discussed, and not only are some immediate problems resolved, but return visits are not stigmatized or feared as had been the case earlier.

Growing out of these sessions have been several community projects. One of the projects which the women's craft group has developed in conjunction with other community agencies is a monthly visit to all of the

elderly Apache in nursing homes away from the reservation. Local facilities for the elderly are not available, and the most used resources are in Phoenix, over 100 miles away. Each month a trip is planned and transportation provided for a family member if they want to visit. Home prepared foods, especially of Apache traditional types, such as acorn stew, are prepared, and other gifts and necessities gathered together. Overnight accommodations are arranged in Phoenix, and a group travels together to ensure that each reservation elder receives visits and respect, and that families stay in touch. Much of the financing of this project comes from the sale of the beadwork and other craft articles made in the Guidance Clinic sessions.

A similar use of the Guidance Clinic facility by teenagers was being developed in 1973-74, with the Guidance Clinic funds supplying a pool table and some staff to help keep a teen center open during the afternoon and evening hours. The trends toward low self image, school failure or dropping out, and other problems common to this age group are hopefully being counter-acted.

A special education program that provides kindergarten and school preparatory experiences for children with special needs was housed in the Guidance Clinic -- utilizing a remodeled area that had been a two-car garage. Work with these children could thus be coordinated with IHS clinics and with the Headstart and local schools.

Much of the counseling case load was carried on by the psychiatric nurse, who traveled to homes as well as maintained first-person

contact at the Guidance Center itself. She reported that her clientele was mainly women and young couples in their 20's and 30's. Where needed the resources of the specialists throughout the network of Guidance Clinics could be called upon for psychiatric examination and consultation or for psychological testing. IHS also provices psychiatric consultation and treatment through the Indian Medical Center in Phoenix.

Although there are many values seen in this Guidance Clinic arrangement, detached from IHS, it poses some problems as well. For instance, since all housing is either tribally controlled for Indian use, or federally for US government employees, the Director, Don Ostendorf, must comute 25 miles to the reservation border. Personally, he is part of neither of the two tightly knit communities -- the federal employees nor the Apache -- and entree into social and community life is thus more difficult. The salary differential has also been mentioned, and usually leads to relatively high turnover of the paraprofessional staff, with the Guidance Clnic providing entry level training, but other organizations providing upward mobility in terms of pay and status. In spite of these problems, however, the arrangement seems to be working well, and some basic patterns seem to be established for collaborative problem solving.

2. San Carlos Apache

a. Description of the Reservation

The San Carlos Apache Reservation lies just south of the Black River, and south and east of the Salt River which form the common boundaries between it and the White River Apache Reservation to the north. Situated further down on the slopes of the mountains, the San Carlos

Reservation includes some more desert-like land, wide valleys and brushy foothills, as well as some wooded slopes. The southeastern corner shares the northern borders of the large lake formed by the Coolidge Dam on the upper Gila River, permitting recreational facility development. The San Carlos Apache are known as stock men, with special herds set aside not only for breeding purposes but also to provide work for those unable to find employment elsewhere. In addition there are mineral resources to be developed, particularly along the Salt River canyons. Iron-free asbestos deposits have been productive of sought-after insulating materials and one of the two known sources in the world of the gem stone Peridot is presently being mined as a tribal enterprise.

The San Carlos Apache are no longer feared by outsiders, but their aggressive and secretive traits tend still to cause some disturbances within the 6,000 member tribe. Particularly, it is noted that gossip and "bad talk" have tended to travel rapidly, but that good news, achievements, and recognition do not spread as widely and speedily. This is most probably complexly related to cultural traits, some of which had survival value in the past, but which many Apache now recognize as divisive and destructive of group morale, A new tribal newspaper, and an effort to reverse these trends is beginning to show results.

Many community activities characterize the reservation, but only in the very recent past have welfare and health-related activities emerged from federal domination to become community sponsored, tribally directed and actively developed by the Apache people themselves.

b. Early Report on Mental Health Needs

For a more specific understanding of the population and activitie of the San Carlos Service Unit, Dr. Elite's 1968 report on San Carlos follows:

> Unfortunately, there is a paucity of data regarding mental health problemns on the San Carlos Reservation. However, it is the strong, general impression of all professional DIH staff that alcoholism is the major mental health concern affecting both male and female Indian population. Again, it was emphasized that many other problems, such as child neglect and family break-ups, are invariably tied in with excessive drinking. The emergency room has been receiving more trauma connected with excessive drinking. However, this may not represent a true increase in numbers of different patients within the community, but an increase in the number of repeaters seen for emergency treatment.
>
> Within the San Carlos Reservation there seems to be a concentration of mental health problems in the Bylas community. Child neglect and excessive drinking among women is particularly prominent. In general, it has been observed that the community of Bylas is quite resistant to changes of any sort. It is felt that the basic morale and attitude of the people in the Bylas community is the lowest on the reservation. Social Service evaluations are provided by the DIH Social Worker and appropriate psychiatric referrals are made to Phoenix. Negotiations are in process for utilization of the new State Mental Health Clinic currently being set-up in Globe.
>
> In mental retardation cases the service unit staff has been working closely with public school officials and BIA. They have jointly developed an evaluation program of Indian students on reservation who are considered "slow learners." There are PHN-teacher conferences regarding students having problems.
>
> In the area of alcoholism several surveys have been conducted by anthropologists to determine the extent and etiology of alcoholism and to document Apache drinking patterns. Negotiations are in progress at the Area level for continuation of these studies, with emphasis on treatment application. The social worker and other key staff have been working with community resources and are trying to develop a comprehensive alcohol program. To date, only moderate success has been obtained, primarily using the A.A. approach.

c. Later Statement -- 1973-74

The following "Resume of Problems" was prepared jointly by the Tribal Chairman, Marvin Mull, and the SUD Gordon Jensen, with consultation from William Hanna, Ph.D., IHS Mental Health staff person at the San Carlos Reservation. This report not only supplies detailed information on points raised by Dr. Elite, but it also suggests both the developing awareness of difficulties, and some steps being taken to resolve them.

RESUME OF PROBLEMS

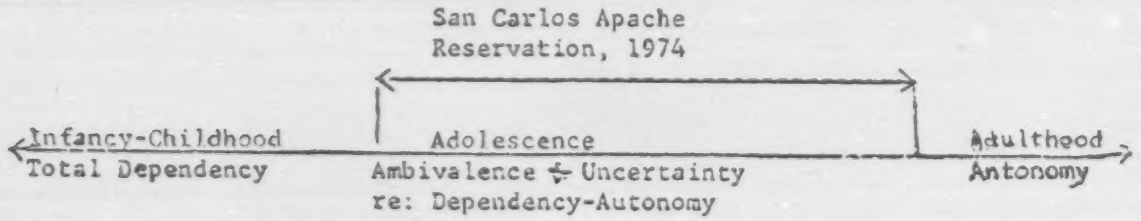
Overview

A resume of our problems could become a very lengthy document. Many of these problems are not uncommon to other Service Units. Most of the specific problem areas are picked up and dealt with in Program Plans and Program Packages, yet the situation in which we find ourselves today goes beyond the individual problems enumerated. There are basic philosophical issues to be faced. Until these are addressed, and resolution initiated, little more than fire fighting, crisis management, and crisis medical care can be provided. The Service Unit is caught in the middle, attempting to deal with two sides over which it has little control. On the one hand, higher level Federal Bureaucracy shackles the program, places demands on lower levels, and yet remains unresponsive or indecisive to numerous requirements. On the other hand, the Tribal organization is ambivalent, uncertain and unable to determine its role in health care. Often Tribal leaders, confronted with Federal ambivalence and their own insecurity, escape by avoiding prolonged and involved responsibility.

In an effort to conceptualize major philosophical problems confronting the Service Unit and the Tribe, we call attention to the following main issues:

The Issue of Self Determination vs. Dependency

The San Carlos Apache Reservation celebrated its 100 anniversary last year. Over one hundred years ago the Apaches were a self determined people, free to roam and function independently throughout the Southwest and Mexico. With the subjugation of the Apaches and the establishment of the reservation, their autonomy was destroyed. They were relegates to the position of "children"-the Federal Government assuming a parents role. They were essentially told by their new "protectors", "you be good little Indians and we will take care of you." This conditioning to abasement and succorance continued for four or five generations. Recently this has all changed. The Federal plan now calls for Indian "Self Determination". This is done with little preparation-they are suddenly expected to change a life style taught and enforced for generations. To make the problem more clearly understandable, it might be cast historically in a human development model and illustrated as follows:



As shown on the above graph, the current status of the San Carlos Apache Reservation is seen to be "adolescence". For the Indians, there is an identity crisis with typical ambivalence and uncertainty. Unfortunately the Federal Government (as parent) is of little assistance as it, too, seems to be very unsure of its role in the many issues centered around the maturing Indians.

As a result of the basic issue of self determination vs. dependency illustrated above, wide are the ramifications and numerous are the problems faced in San Carlos health care planning and delivery. Only a few will be reviewed in succeeding paragraphs.

The Indian Health Service talks of the importance of Indian involvement in decision making, yet will not allow participation in personnel selection. Self determination should mean learning to work within the system, yet there is no formal plan for community input. With the "Chain of Command" system, all decisions necessarily come from the top. One wonders if consumer involvement is really viable in the Federal system. Is talk of Indian control a game we are playing?

Tribal leaders say they want more involvement in health matters but provide little more than occasional criticism of health delivery. The Health Committee seldom meets and has frequently "stood up" hospital staff when announced meetings failed to convene. The Tribal Council has refused to deal with certain touchy health related concerns, referring them back to the Health Committee where they become lost to action. When negotiating for an important $45,000.00 Maternal & Child Health contract in the Spring, 1974, a Health Committee quorum was not present after two scheduled meetings. Finally the Tribal Chairman had to arbitrarily sign for continued funding because the Committee failed to do its job.

Many individual Apachas and families are perpetuating institutional dependency regarding their health care and seem ready to let IHS do the worrying about delivery. They often take little initiative for their own care, knowing that someone will be around to take care of them. Yet there is a sense in which each reminder or follow up attempt is a "put down" of the Apache.

Indian hospital employees are often reluctant to assume leadership in special projects, deferring usually to Anglo counterparts. This is particularly true when it involves extra time and effort without compensation. For too long there has been a dependency on white professionals---especially Commissioned Corps personnel--to do this. In their zeal, insecurity, and commitment, these professionals have often been only too eager to fall into this trap of continuing paternalism. After two years of service they frequently leave San Carlos bitter, and the process is repeated with the new crew coming in. Unfortunately local persons have not been prepared to do this work.

To carry the analogy one step farther, there is a typical "communications gap" between those playing "parent" and "adolescent" or emerging adult roles. Both within the Service Unit and the community, there has been a continuing problem in communication between Federal bureaucrats and community members. Apachas often feel "someway" but repress the im-

to discuss it. Characteristically this feeling leads to an apparent lack of initiative, alcohol abuse, or other escape behavior. Bureaucrats often do not try to break through this communication barrier and are content to go on without "rocking the boat". These barriers, however, build up resistance on both sides and impede the maturing process.

The Issue of Political Conflict

It is a well known behavioral phenomenon that where a major conflict exists within an organism or organization, blocking or stalemate to some degree always occurs. This has been clearly demonstrated in recent events surrounding politics at the Federal level. Tribal leaders and members have also been frustrated by their own infighting. Rather than working together, the people are divided and the community is disorganized.

During the past four years, numerous gains have been made in health care. Professional services have been increased and environmental health changes are well underway. Tribal programs for community health representatives, maternal-child health, alcohol abuse, juvenile concerns, etc. have been initiated. Yet most of these programs have been instigated and funding secured by civil servants assigned to the reservation. The Tribe itself has done little to effect these changes except to note a problem, or agree to a plan, or pass a resolution, or sign the necessary documents. In some cases even this was not required of them. Changes were made completely independent of their input.

Political preoccupation and infighting have held back certain programs which are recognized by the Tribe as desirable. Key directorships and positions have frequently been decided in respect to politics rather than qualifications. Ineffective directors have often been maintained for political reasons even though their programs are failing for lack of effective leadership. Program accountability to the Tribe (as grantee) is seldom required. Attempts to require program or personnel performance sometimes fails because pressure for this is countered by the threat of political blackmail. The Federal Government has talked much of "tightening down" and making the grantee responsible, but there is little concrete evidence that this is taking place. At the expense of Indians, "political football" is being played by Federal agencies who provide funding and advisement.

In San Carlos, as in all societies, politics are all pervasive. However, due to the geographical unity/isolation and social interdependence of the community, everyone seems directly influenced by the mechanics. The outcome of an election could mean jobs, dignity, and life. It is a sad commentary on the fears and conflicts centered in politics to recognize that the approaching 1974 Tribal election brought increased tension, alcohol consumption, and violence. The immediate effect of the campaign has been disruption, destruction, and demoralization. Interpersonal ruptures occuring during the process may take a long time to heal.

This politicising of all of life in San Carlos creates severe problems for both the Tribe and the Service Unit. It directly effects the health delivery system at many levels. Although Indian Health Service officially stays out of politics, our programs and personnel are influenced by ...

As a beginning, in resolving these problems, the Service Unit agrees with the Tribe that there must be an employment system established which is based on merit and is, as much as possible, free from politics. Also the Service Unit recognizes a critical need for a viable Health Board or Committee which represents the community and its people, is accountable to them, and, in turn, makes the Service Unit responsive to community need. Finally, the rights of Apache hospital employees must somehow be clarified so that they can assume places of responsibility in Tribal government.

Conclusion

In conclusion we wish to state, again, that the problems which have been verbalized are not unique to us nor to our community. They are, however, underlying issues with which we are daily confronted. It is important for us, and for Indian Health Service, to avoid the trap of tunnel vision ...failing to see the whole due to a microscopic concentration on the parts. We must not busy ourselves treating symptoms or cursing effects. We must be aware of underlying conditions and look to an understanding of causes if we are to heal and be healed. The increased emphasis on mental health, preventive health, and community health are good signs that we are beginning to look at the "whole" person or community.

Perhaps, more and more, the Tribe should look to IHS, locally and at Area level, as a "resource" to help them in the development of their own human resources. No doubt San Carlos IHS should assume an increasing consultative role—especially in community health. Perhaps we should do much more to prepare individuals and the community to assume the responsibility which true "self determination" implies. Maybe IHS can assume a greater teaching role and less of a "doing" role. Perhaps Tribal members should become more active and eager in the learning process knowing that the student always has the potential to surpass the teacher if both are willing to work at it. Possibly now is the time for the Tribal Education Committee to begin affirmative action in identifying bright young people and recruiting them to be educated for positions in human services for the future.

There is no more appropriate arena or domain for testing human resource development than in community preventive health. Here seasoned professionals can work side by side with apprentice community members. Case conferences can be held. Study should be ongoing. Apaches can learn by doing. In a short time, it will be clear that well selected, eager, committed, and trained Native Americans are more effective than their Anglo counterparts and tutors. If all this is to take place, however, there must be a commitment by both the Tribe and IHS to make it happen. Continued fire fighting and crisis intervention could occupy everyone's time and no progress will be made in prevention and viable self determination. The time is overdue to move beyond mere health maintenance and gear up for effective programs in the development of the vast potential in Apache human resources.

In the Emphasis Plans which follow, interest in community and preventive health is demonstrated. More than half of the Plans are community related and almost half deal with preventive health care. If these plans are realized, we will be taking steps in the right direction. A total

resolution of the problems we have described may take many years. Even as the present conditions affecting San Carlos were not created overnight, they will not be immediately resolved.

Healing, health, and progress begin and thrive with honest communication. We need more dialogue. It continues with a mutual understanding of where the Apaches came from, where they are, and where they wish to go. It moves forward through an honest evaluation of what is expected of each member of the team...an assessment of what each contributor needs and how he can help. Above all else, we must cooperate. Authenticity, self respect, and self determination will again belong to the Apache if he wishes them and if the Federal Government is big enough to plan for them, pay for them, and allow them to happen.

This "Resume of Problems" was approved for inclusion in the Service Unit Program Plan Manual, FY 75.

Marvin Mull, Sr.
Tribal Chairman
San Carlos Apache Tribe

Gordon Jensen
Service Unit Director
San Carlos Indian Health Service

d. Alcoholism Program

A second tribal agency is the growing alcoholism counseling agency which also utilizes the IHS consultant. The Mental Health Technician is a member of its board of directors. The alcoholism program does not have a complete range of services, but is working toward them in many ways. It has, in addition to an active counseling staff, a work program utilizing the Peridot mines and other tribal projects.

The IHS Hospital serves as a medical back-up, and occasional detoxification facility. There are also resources in Phoenix for hospitalization, but these are at such a distance (100 miles or more) that there is reluctance to use them except in cases of extreme urgency. A halfway house or group living arrangement is badly needed and is high on the list of goals of the group. Interestingly enough, some borrowing of ideas from the Jicarilla Apache in New Mexico is being discussed, particularly that aspect of their program which enables them to assign men to tribal work projects (a woodlot) located at some distance from the communities of the reservation, and enables a physical and emotional renewal to take place in an Apache-controlled setting, with active participation by the alcoholism counselors. At the present time some use is made of the Peridot facility for both manual labor and developing crafts skills as part of the rehabilitation process. There is frank discussion of the fact that both men and women on the reservation are utilizing the alcoholism program, and that both sexes have an almost equal need of the facilities presently available and planned for the future. This contrasts with many such programs which are oriented almost entirely toward the male alcoholic.

e. Emerging Health Care Facility

As part of an emerging trend toward planning which involves San Carlos Apache personnel working with non-Indian professionals, a Comprehensive Health Center planning proposal was presented to HEW in 1974 and has been funded. This proposal has received support from IHS, BIA, the White Mountain Apache Tribal Alcoholism Program, the National Apache Council, and the San Carlos Tribal Committee. It is presented in a somewhat shortened form because the planning grant and the program it projects are an illustrative model of programs which could be developed in other settings. This proposal required several years of work before the tribe was able to devise a plan, and the local effort is essential to its success if paternalism is to be overcome. Successful implementation will depend on being able to recruit and hire leadership with appropriate personality characteristics and cultural empathy as well as technical expertise. Nevertheless, as one of several examples, the program format itself is worth careful study as a product of tribal/IHS collaborative ventures.

RESOLUTION NO. 72-55

WHEREAS, The San Carlos Apace Tribe has always been interested in the total welfare of its members. In the past this concern has been responsible for general health, welfare, economic development and educational activities involving Federal, State, and private agencies. Recently specific tribal programs dealing with the problems of alcoholism, juvenile delinquency and displaced children have been initiated. The most sophisticated of these programs to date is the Juvenile Diagnostic Center which is receiving recognition as a significant pilot project and

WHEREAS, It is the strong feeling of many tribal leaders that efforts to correct existing social/psychological/medical problems must be expanded if reservation needs are to be met. The alcoholism program is only at the beginning stage of development. New programs focusing on the returning criminal and the on-reservation residential care of the elderly must be initiated and

WHEREAS, The Tribe has at its disposal a 200-bed facility, formerly used for a Job Corp training center, which could serve to provide centralized therapeutic care for persons in all programs mentioned and

WHEREAS, The idea of a culturally oriented, centralized comprehensive care facility is unique and innovative. Cooperation with the White Mountain Apaches in certain aspects of the program also enhances its appeal. Conceivably adjacent reservation communities will likewise be interested in cooperating with respect

respect to Apache [illegible] municipalities and;

WHEREAS, The first logical step in developing the overall program is to request a planning grant from the Department of Health, Education and Welfare (HEW) to provide well researched ground work for the total program.

NOW THEREFORE TO BE RESOLVED that the San Carlos Apache Tribe initiated and fully supports the concept of a comprehensive care facility and authorizes the Tribal Chairman to make immediate application for planning funds that would develop the total program on a sound basis. The Tribe will make facilities at the Job Corps training center available for use as they are needed to support the program.

CERTIFICATION

I, the undersigned, Secretary of the San Carlos Council hereby certify that the San Carlos Council is composed of 11 members and 8 were present at a Special Meeting thereof held on this 31st. day of October, 1972; and that the foregoing Resolution No. 72-55 was duly adopted by a unanimous vote of the Council, pursuant to the provisions of Section 1, (a), Article V, Amended Constitution and Bylaws of the San Carlos Apache Tribe, effective February 24, 1954.

Janie B. Ferreira

Janie B. Ferreira, Secretary
San Carlos Tribal Council

NARRATIVE ACCOUNT:

COMPREHENSIVE CARE CENTER (PIANNING)

INTRODUCTION

Overview of population to be served. The San Carlos Apache Reservation constitutes the primary population and is comprised of approximately 6,000 residents living on 1,877,216 acres of land located in the Gila, Graham, and Pinal Counties in Arizona. Adjacent to San Carlos, to the North, is the White Mountain Apache Reservation where 6,500 Apaches live on the 3,600,000 acres. It is estimated that 1,000 additional Apaches live off reservation within communities in close proximity to these two reservations.

Officials and citizens from both reservations and surrounding communities agree that alcoholism constitutes the primary social, medical, economic and psychological problem for Apache Indians. Virtually every reservation family is affected adversely by its impact. In San Carlos alcohol was a dominant factor in over 70% of all arrests in 1972 and more than 50% of all deaths were due to alcohol-related problems.

Other Apache tribes, and populations, in the newly formed Apache Nation Alliance include Mescalero (1,933), Ft. McDowell (345), Jicarilla (1,928), Yavapai (105), and Tonto (65). The extent of alcohol-related problems on each of these reservations is similar to that stated for San Carlos. These tribes have all expressed an interest in this proposal and will be included in the planning phase of the program. It is hoped that each Apache tribe will benefit from the research, training, and treatment generated by both planning and implementation phases of a Comprehensive Care Center. For the purposes of this proposal, however, information and statistical data will relate to San Carlos principally and White Mountain to a lesser degree.

Current efforts to deal with the problem and the evolution of an idea. Both Fort Apache and San Carlos reservations have received continuation grants for existant alcoholism programs. In each case, the program is minimal and only beginning to scratch the surface. Additional related services provided by BIA, USPHS, and other tribal programs bring these agencies into frequent contact with the alcoholic family. All present services and programs, taken jointly, are not sufficient and usually lack coordination. There is duplication of service in some cases while dangerous gaps exist in others. Approximately $2,000,000 in federal money is being pumped into programs and services to the San Carlos Tribe. Care givers feel that much of this is necessitated by alcohol related medical and social problems.

Increasing negative statistics surrounding alcoholism dictate that we are not presently doing the job in either prevention or treatment. Mounting personal/family casualties associated with alcoholism do not denote apathy on our part. They do underscore our frustration and commit us somehow to do something by way of intervention in the destruction of our people.

For a long time we have thought and debated what we should do for this overwhelming problem among the Apache people and other Indians who live among us. Tribal leaders and committees have explored various possibilities. We have made several slow starts. Finally we came up with the idea of a Comprehensive Care Center to be located at the old Job Corp facility in San Carlos. We invited USPHS and BIA personnel to advise us in the design of an appropriate program. Though the idea for use of the center originated in San Carlos, our other Apache brothers have been quick to express their desire for a joint effort in an assault on our mutual problems. The tribes will appoint an all-Apache steering committee of interested persons to provide the impetus and inspiration to see that the program is planned, designed and implemented. No one is more concerned about our people than ourselves! We provide our own best advocacy.

Clarification of the problem. As previously stated, this proposal recognizes alcohol abuse and alcoholism as being the greatest problem facing Apache Indians. Traditional and current efforts to deal with the problem are not sufficiently successful. Tribes are losing ground in the battle against alcohol abuse.

Some of the special aspects of this problem include the following considerations:

1. Indian drinking patterns have distinctive features as reflected in most of the literature on the subject. Causes of alcohol abuse and strategies for treatment must be sought within the framework of tribal historical, economic, social, and cultural circumstances. There is little doubt that Apache camp (family living units) and community interdependence presently provides the setting for alcohol abuse. Could it provide a treatment base as well? A planning grant, research and a demonstration project could explore relevant and innovative socio-cultural approaches in alcohol abuse treatment and prevention for Apaches.

2. The multi-agency/program network on reservations leaves much to be desired. Programs are sometimes competitive, repetitive, overlapping and fail to provide coordinated and progressively adaptive strategies in alcohol abuse study and treatment. Agencies and programs are also grossly overworked. If the tribes can take the lead in solving this problem (self determinism) with various agencies contributing expertise and monies, we could be on our way with the framework for a progressive, working system rather than the present one which is fractionalized and often inefficient. Is this tribally operated umbrella program feasible? Could the tribe serve as coordinator and

referral source for the multitude of alcohol related problems?

3. There is a crippling lack of informed leadership on Apache reservations to deal with the problems of alcohol abuse. Many people are interested and concerned. Tribal governments want to do something about the problem. Current tribal alcoholism workers and governmental professionals are overwhelmed by the magnitude of the problem. There must be a center for the objective study of Apache alcoholism. Potential leaders must be oriented and trained in strategies which will be effective.

In summary, there is a growing alcohol epidemic on Apache reservations which is compounded by cultural and family interdependence, bureaucratic inefficiency, and lack of oriented communities and trained workers.

THE CONCEPT OF A COMPREHENSIVE CARE CENTER

Alcohol abuse and interdependence. We have long known that many of the problems Apache people face are simply differing faces of a many-headed monster. We have seen, again and again, the snowballing of economic, familial, social and health problems that occur when an adult in an Apache household becomes addicted to alcohol. It is clear to us that a single alcoholic in a family, and particularly when this individual is a parent, can wreak havoc in all directions. We know that the alcoholic parent often

--drives his spouse to drink, thus widening the devastation,

--forces the family to endure the more denegrating aspects of being welfare recipients,

--ensures that his children will have a high probability of becoming truants, school dropouts, juvenile delinquents and alcoholics,

--guarantees that every drunken act and word will tangle him ever more deeply in the net of alcohol dependency,

--drinks himself and/or others to death,

--sets in motion a syndrome of mutually reinforcing handicaps which will affect every member of his family and reverberate in the community for years.

As we have pointed out elsewhere in this proposal, many dollars are spent by individual Apaches, by the various governmental agencies and by religious institutions, all in a somewhat futile attempt to deal with the problem of alcoholism. Our idea of a comprehensive care center could bring the ineffective programs, money and personnel into an integrated offensive against our Number One enemy.

Probable components of the Comprehensive Care Center. If it is true that alcoholism and the host of difficulties it creates comprise the majority of problems our people face daily and if it is also true that our counter-attack is clumsy and poorly coordinated, then we must, quite literally, pull ourselves together. The comprehensive care center is visualized as one

which focuses all available resources on the tasks of alcoholic recovery, rehabilitation and rebuilding. But to accomplish these goals, we must do more than simply care for the alcoholic's needs--we must also aid those whose lives have been adversely affected by him.

1. Alcoholism component. The primary purposes of the Center would be to provide the alcoholic with emergency care, halfway house treatment (recovery), family counselling, vocational guidance, job placement assistance and to aid him in returning to his family and community. Additionally, the Center would have a "receiving center" component which would conform to the newly implemented Arizona statute requiring that drunk people be taken to facilities other than municipal drunk tanks.

   Through NIAAA and State of Arizona grants, there is a small alcoholism program currently in operation, but it is admittedly a very small weapon against Apache alcoholism. The Comprehensive Care Center would expand the program by giving us the residential, recreational, occupational and personnel tools to really fight our enemy on even terms.

2. Ex-criminal recovery component. Ex-criminals frequently become involved with excessive drinking which ultimately leads them back to prison. All too frequently the crime which caused their original imprisonment was committed while under the influence of alcohol. Our center would provide the releasee with a place to live, a community of his own people, vocational and occupational guidance, job referral assistance and a variety of supportive people to help him put his life back together. The center's major emphasis would be the releasee's socio-economic return to his home community.

3. Child care component. Alcoholism uproots many youngsters from their homes. Children whose parents are severely afflicted with the disease are often genuinely homeless and in need of emergency care. Pending custody cases, desertion and the fear of the violence of drunken parents would bring youngsters to the center where fundamental physical and mental health needs could be met.

   As in the case with the recovering criminal and alcoholic, the major objective would be to restore a child to healthy family experiences. Our center could make it possible to work with an entire family in an intensive, growing and productive manner. It is not too far-fetched to imagine a process whereby individual family members could be systematically brought into a newer and healthier family relationship.

4. Youth component (juvenile). Juvenile delinquency (in all that the term means and implies) is a problem that is keeping pace with the distress caused by alcoholism. Our reservation presently possesses a Juvenile Court System but its rehabilitative scope is limited by the absence of adequate recreational, study and educational possibilities. These could all be constructed within the comprehensive care

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center. To reiterate an earlier point, we consider juvenile delinquency on this reservation to be very largely the result of parental alcoholism, so this component would be a necessary one in any integrative approach to rebuilding the lives of alcoholics.

5. The aged component. It is a constant problem to adequately care for the elderly and even more so when they are either alcoholics or the victims of neglect caused by alcoholism within the family. Off-reservation institutionalization is confusing and very frightening to elderly Apaches and our center could go a long way toward providing them with a comfortable and familiar environment. The advantages to the old folks are quite clear and it cannot be ignored that there is much in the way of knowledge and affection they could pour out on the younger residents of the facility. In fact, we visualize the comprehensive care center as a large family residence where each individual is both giver and receiver of help--each is an integral part of the recovery of others.

In summary, a residential comprehensive care facility would be the major mechanism by which we could pull together multiple services to confront multiple problems. Alcoholism causes extensive damage to Apache lives and we believe that our approach would provide an integrated attack.

The proposed facility. Fortunately, our tribe owns a 200 bed facility, formerly used for Job Corps and Manpower Training Centers. It is equiped with laundry, kitchen, storage, eating, classroom, office, recreational maintenance, vocational shop and residance facilities. With rennovation and equipment replacement, it would be an ideal site in and around which the comprehensive care center could be developed.

The advantages of a Comprehensive Care Center. There are numerous benefits in having a central care center--a therapeutic community. Among these advantages are:

1. The opportunity to throughly research Apache alcoholism and to develop treatment and prevention modalities which will significantly reduce the incidence of alcohol abuse.

2. Incorporation of the traditional Apache life style--that of extended family patterns. Rather than caring for the Apache client in an isolated setting, he would be treated in a homogenious cultural, family and language milieu.

3. Separate facilities require costly duplication of programs, staff, and services. This program offers the possibility of one kitchen, one linen supply and laundry, one motor pool, one large and diversified recreation program, one inservice training program, one occupational therapy program, etc.

4. Programs dealing with the multi-problems generated by alcohol abuse could all be headquartered, directed and coordinated

from a single umbrella operation. This should result in significant cost savings, improved care, and a higher success ratio.

5. The center can be a referral source for Apache clients from other reservations, but also can serve as a training center for satellite operations on all reservations.

6. The immediate total use of an under-utilized, tribally owned facility which could provide inestimable benefit to the tribe. Whereas Corporations or institutions might be willing to pay well to use these facilities but the long term advantages to our people, in terms of mental and physical health, could be priceless if this center could be developed for comprehensive care as described.

7. With a total community (San Carlos) and a total culture (Apache), we will be able to research, design, and test an appropriate and innovative therapy for generalized productive living. Because the population is small, it is conceivable that the behavioral therapies and preventive strategies developed could have profound influence on the whole community. In all cases, Apache people will direct and design the ultimate plans with the help of contracted professional employees or consultants.

A PLANNING GRANT

Purpose for this grant. Due to the all-pervasive nature of the alcoholism problem in the target population, our long range goal is to mount a multidimensional attack on the problem. The ultimate plan is to develop a center which can address the needs of the aged, youth, and children who all, in some way, have been victims of reservation alcoholism. The aged, abandoned or neglected children, juvenile delinquents, returning criminals, and alcoholics in need of a receiving center and recovery program are all included in the plan. The project will seek to work with the families within the community cultural milieu. We strongly feel that a treatment center at home, among family and tribe, is needed and is vastly superior to the isolation often encountered in distant places.

Research into the unique causes and treatment of Apache alcoholism needs to be done. Plans for a comprehensive care program will have to be carefully made to provide optimal success. Grant and income sources must be identified and tapped. The BIA and USPHS both have expressed keen interest in this Tribal idea and have committed themselves to cooperate in its development and implementation.

Thus, in order to prepare well and lay a solid foundation for an effective Apache Comprehensive Care Center, our present and immediate need is for a grant which will fund planning toward the realization of our goals. Time and money expended at this level should provided as excellent base out of which the ultimate goal will be achieved.

Objectives of a planning grant. The objectives for this planning proposal are the following:

1. Secure a qualified director of planning, with office support, who will work with the steering committee and consultants in studying Apache alcohol abuse and developing an Apache Comprehensive Care Center.

2. Identify the variables contributing to Apache alcohol abuse and design a treatment plan which will counteract the contributors.

3. Provide training and field trips for steering committee members and tribal leaders to thoroughly orient them in understanding causes, treatment and prevention so that they will make informed decisions in ongoing planning.

4. Identify and secure the services of key consultants. Consultants would be made up of contract personnel and also agency experts who could be utilized without direct cost to the program.

5. Develop working plans for coordination of funds and services with on-reservation agencies and interested groups such as BIA, USPHS, OEO, etc.

6. Study the most efficient utilization of skill center facilities and determine remodeling and expension needs.

7. Detail personnel needs which will exist if center plans are implemented. Design preservice training programs for persons interested in employment at the center. (It is estimated that the work force of 80-100 will required when the plan is implemented). Establish a skills bank of potential employees.

8. Make plans to provide input from the target communities with respect to programs, remodeling, etc. Since the idea was conceived by the people, it is essential that they be allowed to continue to make it their center.

9. Explore and make contact with other funding and income sources. Develop and submit program proposals. Invite interested persons and groups to tour the center to get "the feel" of what is developing. (The total budget requirement is expected to be in the area for $1,000,000 for the first year of full operation).

10. Develop or encourage the development of industries which would provide employment for persons involved in occupational therapy.

11. Develop relevant training programs for clients out of which persons graduated might seek meaningful employment both on and off the reservation.

12. Establish liaison with adjacent non-reservation communities so that Indians picked up on drunk charges could be treated at the Center.

13. By the end of the planning stage be ready to implement plans, with committed funds, for an Apache Comprehensive Care Center to be housed at the Job Corp Center in San Carlos.

Advantages of a planning grant. The primary advantages of securing an immediate planning grant include: (1) basic research (2) comprehensive planning, (3) resource identification, (4) coordination of existing services, (5) provision for a centralized office and personnel to "carry the ball", (6) training for steering committee and tribal leaders so that decisions can be best made, (7) development of a skills bank of trained and interested personnel.

Implementation of an Apache Comprehensive Care Center would bring numerous advantages. Among these benefits are:

1. A better understanding of the causes of Apache alcoholis, how it is reinforced, and how it can be prevented or treated. This will lead to the recovery and rehabilitation of our people.

2. Intervention into the spiraling personal and family casualties associated with alcoholism and problem drinking.

3. Job opportunities for many reservation Indians, along with appropriate preservice or inservice training.

4. Economic gain due to new industries attracted by the labor pool created by the Center.

5. Agricultural gains growing out of garden therapy programs at the center. Clients learning to grow vegetables and fruits could carry this to their homes where total families could benefit recreationally, nutritionally, and economically.

6. A significant reduction of police, medical, welfare, and psychiatric activities due to the lessened incidence of alcohol related distress on the reservations served.

EVALUATION

Evaluation of the planning phase can easily be made in terms of whether or not the thirteen (13) objectives of the grant have been achieved. If all objectives are met and a center is established, the planning grant will have been highly successful. If only the research and training aspects of the proposal are satisfied, the grant will still have produced good results in terms of a more informed and efficient operation in current facilities. A year's focus on Apache alcoholism is bound to result in numerous ongoing benefits.

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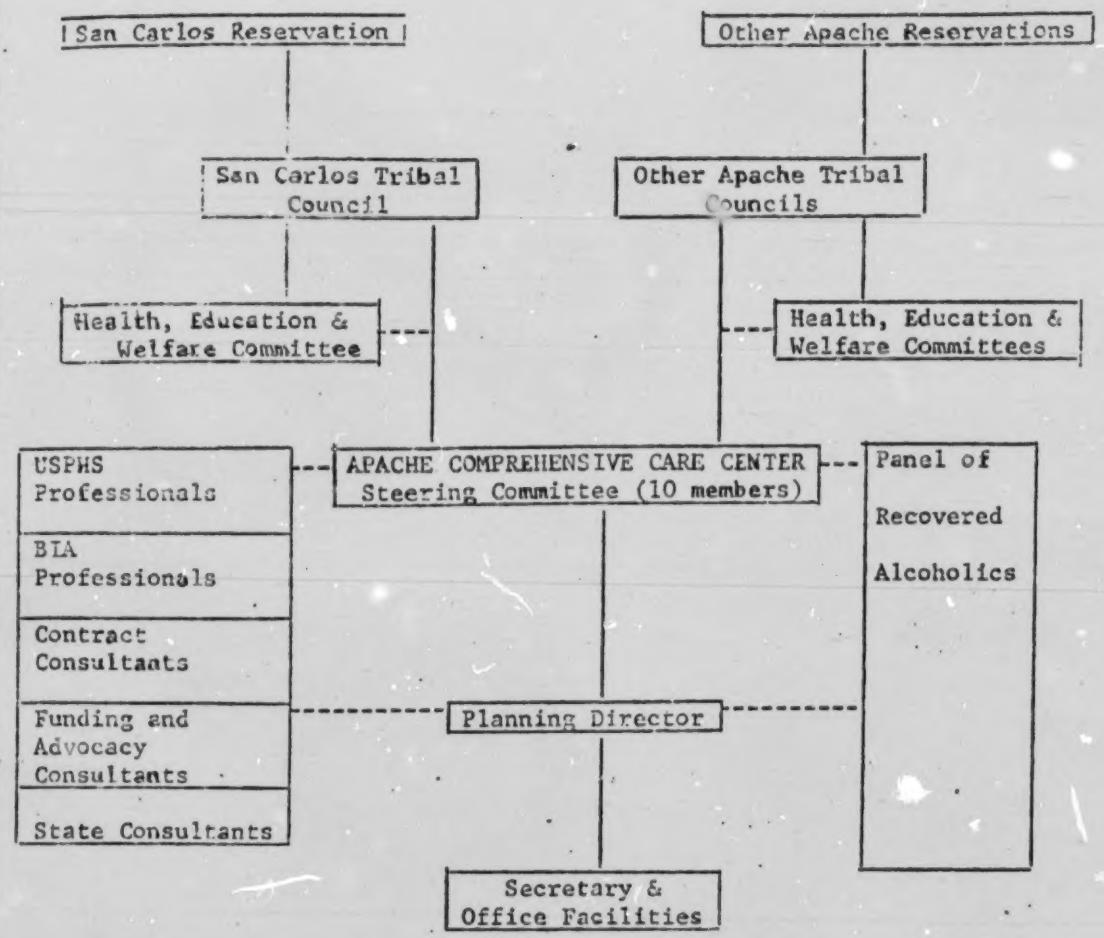
ORGANIZATIONAL CHART FOR PLANNING GRANT



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f. The Apache Youth Movement

The Apache Youth Movement is a strong creative organization for adolescents, which places a primary emphasis on developing interests in school achievement through high school. All Apache youth must attend high school off the reservation in public school settings where discrimination has been a bitter experience for many. The Apache Youth Movement seeks to reward school attendance and achievement in a variety of ways. One is a party held monthly for all with a C average or better. Those falling below a C average are tutored by those with better grades in hopes of becoming eligible for the next affair. Both those receiving and those giving tutoring are paid nominal sums, with a higher amount going to the tutors. This group also has recreational projects and participates through its representatives in many community meetings and activities. The Mental Health staff has been active in the consultant role from the beginning of this program, assisting in grant and proposal development and as consultant to the leadership.

g. Other Activities of IHS Mental Health Staff at San Carlos

There are close working relationships also with the Community Health Representatives, the Community Action Office, the various welfare agencies, both federal (BIA) and state, and with the school counselors and church leaders on the reservation. The beginnings of a tribal businessmen's program is available, as for the first time Apache individuals are seeing not only the need but also the possibility of providing the necessary services of newspaper, insurance, and possibly even stores and funeral parlor operations themselves. This is something which is just beginning,

but should contribute to the development of pride in both individual and tribal identity as it slowly builds.

In consulting to these programs, and being available to all parts of the reservation, Dr. Hanna is seen as a facilitator, but not as someone who takes over and operates a project. There is always some ambivalence about this in any Indian program, but it would seem from observation that both he and the Apache people with whom he works are developing a working definition of "consultant" which coincides with this concept. The fact that in public meetings there is expressed a need for a Mental Health Technician in more of the communities of the reservation seems to be an indication of the success of this staff in providing both clinical services and consultation in forms which can be utilized and which have not fostered dependency. The support and close working relationships of other IHS staff help to make this possible.

Illustrative of the manner in which the Mental Health staff are seen by the total community was the reaction to an error by another fedral service. As part of a campaign to control the cattle-parasitic screw worm, which is a fly larvae, cartons of sterile male flies were being dropped over the reservation at the time of a site visit for this project. Either due to wind shifts or pilot error, some of these cartons fell on or near the dwellings of several Apache communities. Rumors and fears of distorted nature, some of which testified to the efficacy of the health educator's campaigns on sanitation, were rampant. It was considered as a matter of course that the Mental Health staff should be included in the community

leaders' meetings to calm the population that was reacting to the "bombing" and to negotiate with the other federal agency involved for better planning and information dissemination.

Contact with outside resources at the state and national level is also considered part of the Mental Health staff's function. Out of these has come a series of recommendations to other IHS Mental Health Programs concerning the reporting of consultation activities, and also a sharing of discussions of consultation techniques at training sessions and national meetings.

3. Salt River Pima-Maricopa

On the outskirts of Phoenix, and practically surrounded by the metropolitan development of the city and its suburbs, is a smaller group of Pima-Maricopa on what is known as the Salt River Reservation. This reservation utilizes the facilities of the Phoenix Indian Medical Center and does not have its own Mental Health Program and staff. However, Carl Hammerschlag, M.D., consults with its leaders and is available to that community as he is to several others as part of his PIMC duties.

F. Pima-Maricopa Reservation, Sacaton, Arizona

This reservation lies south of Phoenix, about 50 miles, and about midway between Phoenix and Tucson, Arizona. It has an overall extent of about 350,000 acres, and about 10,000 people. The western portion, with a number of the Maricopa tribe, is served directly by the Phoenix Indian Medical Center. The rest of the reservation is served by the IHS hospital at Sacaton, which estimates that its on-reservation

population is about 6,000, while another 4-6,000 Indian people not living on the reservation present themselves to it for health services. These may be off-reservation Indians or Indians from some of the other Arizona reservations who prefer to come to Sacaton rather than use the larger urban facilities in Tucson.

The Gila River is unique among reservations in having a very active Model Cities program which is serving to concentrate federal funds and to coordinate program development and planning in many fields under tribal leadership rather than in a fragmented manner among the various agencies. In 1973-74 they were actively establishing a tribal health program and recruiting for a director whose first task would be to coordinate existing services, especially those which are presently non-federally operated such as the Alcoholism program, CAP services, and the CHR program and services in the youth homes for pre-delinquent, neglected, and abused children. IHS and BIA, as well as state welfare and social services and IHS Mental Health, seemed logical extensions of this plan, as did some coordination of the programs in the three types of school systems serving the reservation: BIA, Public, and Parochial schools at both elementary and high school levels.

Formerly the Pima were an agricultural people with a well-developed irrigation and farming complex. Shortly after the rerervation was established, reclamation projects for other areas of the state closed off the water supply for the Pima irrigation system, although the remains of its canals and other parts of it can be seen as one travels across the dry and desert-like countryside. However, even though this short sighted

policy aborted economic independence for the Pima, in a manner consistent with planning on other reservations, tribally operated farms, using mainly dry farming techniques, are still being operated. A large percentage of the residents of the reservation find employment off the reservation, or in federally supported programs on the reservation.

Awareness of the fragmentary nature of tribal tradition and knowledge and the need to preserve and teach the language, myths, and history of the Pima are beginning to be a thread for tribal action and planning. The Tribal Cultural Center affords an opportunity for display and sale of Pima baskets and other craft articles, and provides a focal unit around which to organize some of these activities.

In 1968 a brief description of the mental health needs of the Sacaton Service Unit was drawn up and is quoted below:

> The main clinical and field health personnel impressions are that many Indian families live under social, economic and cultural conditions that foster personal deprivation, individual maladjustment and, in general, poor mental and physical health. The severity of the problem is manifested in the high rates of violent deaths, accidents, injuries, suicides, suicide attempts, family disorganization and alcoholism. It is felt that although changes in environmental conditions, job opportunities and education may help stabliize this group of people, experience has shown that often those offered the greatest opportunity to achieve need the most professional help in handling their internal stress.
>
> Mainly through the work of the Gila River Comprehensive Health Committee, significant progress has been made on the reservation in bringing about increased lay and professional recognition of the existence of mental health problems and in heightening the sense of social responsibility for these problems. To date, the main effort of the service unit in the area of mental health has been direct treatment services or referral of patients to contract or State care. Preventive measures coupled with promotion of mental health have received little attention at the present time.

There are three patients presently hospitalized at Arizona State Hospital, and four were hospitalized during calendar year 1966 for mental disorders. There are 27 patients suffering from chronic psychosis in nursing homes.

Like most of the service units, Sacaton is actively involved in case-finding, evaluating and supervising mentally retarded children. In some instances, medical staff recommend placement. Nine patients are presently at the Valley of the Sun School and eight are at Arizona Children's Colony. In addition, 22 other mentally retarded persons are known by this service unit. Some of these children are only mildly retarded and do not require institutionalization.

Antabuse therapy in the treatment of alcoholic patients was begun in the first part of February 1967. This additional treatment procedure is but one aspect of the comprehensive alcoholism treatment program which will combine DIH efforts with those of the Tribal Community Action Program (Alcoholism Prevention and Treatment Center staff, in particular). This center began operation on August 1, 1966 with a professional social worker as director and two indigenous persons as aides. In F.Y. 1966, 29 persons were hospitalized for a period of 141 days due to the effects of alcohol. Of these, 14 were admitted for delirium tremens and one for alcoholic hallucinosis. In the same fiscal year, 59 outpatients were treated for accidents due to drinking, and 25 outpatients were treated for auto accidents in which alcohol appeared to be a factor.

A word about homicide and suicide: In 1966, two suicides and one homicide occurred. Thirteen patients attempted suicide. Violent Deaths: in F.Y. 1966, 21 out of 70 deaths were associated with violence, suicide, homicide or accident.

As of 1973 the Mental Health and Social Services Programs are officially combined under Michael Speshak, an ex- Army Social Worker who has been at Sacaton for at least 6 years. Mr. Speshak devotes most of his time to administrative work and liaison with the IHS hospital where he attends Grand Rounds and exchanges referral information with the various departments. He is a firm supporter of the Mental Health Technician program, citing the many years of success with this use of paraprofessional personnel that has been the US Army experience with the enlisted specialist. As he sees it the Mental Health Technicians when they have been trained

become the eyes, ears, arms, and legs of the professional who is unable to move as freely about the community or to be as acceptable in the sub-cultures it presents.

A psychologist, Ronald Teed,Ph.D. has been full-time at Sacaton since 1972, following a number of years as a part-time consultant. Dr. Teed and Mr. Speshak are both involved in crisis intervention and have comprehensive case loads of mainly adult patients. The role of traditional psychological testing is only filled when testing is needed either by IHS or another agency with whom joint planning for a particular patient is being carried out. Dr. Teed spends another major time commitment in the training or preceptorship of Mental Health Technicians -- not only to IHS staff, but also Tribal Mental Health Technicians who already have recieved some basic training at the Desert Willow Training Center and are into the on-the-job experience level of their two-year training period. Most of these technicians are also engaged in some academic work and will earn an AA degree through the training program. However, the six positions of this type which he anticipated supervising in IHS have not materialized because of budget crunches since he came aboard as a full-time staff member. Consequently, both he and Mr. Speshak feel some frustration in attempting to reconcile the work that they are actually doing with what had been projected.

There has been a long enough established pattern of service availability that considerable demand for clinical service has built up, along with community and tribal acceptance of the therapeutic role to a degree

not always found in reservation populations. Some of this is directly attributable to the fact that both professionals have been available longer than the usual two year turn-over period expected in IHS, and therefore have gained the confidence of the Pima population. The success with which they have rendered services is also a factor in the growing "demand" by both individuals and agencies for more help, sooner, and oftener than in the past.

Some of this clinical load is also carried by a part-time psychiatrist who sees patients in the outpatient clinic on a regular, twice a month schedule. Sanford Meyer, M.D., from Phoenix also serves the Indian population as one of the staff of Camelback Sanitarium, a private hospital to which Phoenix Indian Medical Center refers its psychiatric inpatients. This provides some continuity of care for Pima patients who require inpatient treatment.

The Service Unit Director and the professional Mental Health and Social Services staff share a common view of the desirability of comprehensive program development, with about an equal emphasis on preventive and curative services. However, with the clinical direct services load so great, they have not been able to implement the preventive programs to the extent that they feel would be desirable. Accidents are the leading cause of death on the reservation, and there were about 60 suicide attempts with only 4 deaths during 1972-73. The reservation has one of the highest rates of Diabetes in the country, and possibly in the world. There are more persons 40 and over hospitalized for complications of Diabetes than there are children born in the IHS facility each year. These pressures for immed-

iate direct service, together with the consultation and training programs for other tribal groups, prevent time being freed up for evaluative and preventative mental health activities.

For instance, preventive programming and broad consultation activities are nearly always given a lower priority than dealing with suicide attempts, threats of homicide or arson, and serious marital crises.

It was anticipated that Dr. Teed's work would be concerned with community consultation, and with the training of a cadre of Mental Health Technicians — a minimum of 6 was planned. Since funding problems have resulted in reducing the number of available Mental Health Technicians in 1973-74, the only one available also served as clerk-secretary. A second was commencing training in the beginning academic year. The result kept Dr. Teed tied to clinical work rather than permitting him as much community coordination and consultation as he had pursued on a part-time basis.

In 1974-75 further reductions in budget changed the staffing pattern still further, reducing Dr. Teed to one fourth time, and for a brief period there was no psychiatric consultation. Meanwhile, by turning to other resources the tribe began developing its own inter-agency training programs. This will eventually increase the pool of able Mental Health Technician applicants, so that at some point, if budget permits, a return to original plans may be possible. However, the IHS Mental Health Program as such seems to be deeply depressed and in danger of collapse.

G. Colorado River Tribes

In western Arizona, along the California border, there are several reservations such as the Yuma and the Mohave which have relatively sparse populations, and are served from Fort Yuma or Parker, Arizona. Many of the Indian residents live on the California side of the river, and all are fairly similar to the Maricopa Pima and Tago in their cultural traditions. A few Hopi and Navajo migrated to this region in the late 1920's. Mental health services have been slower to develop on these reservations, partly due to the small numbers, and partly due to their distance from other resources. The Havasupai, living at the bottom of the western reaches of the Grand Canyon and served by the Health Center at Peach Springs, also belong in this group.

1. Service Unit Programs

In 1968 the report of the needs and services available was summarized for Mental Health as follows:

> Colorado River Service Unit, Parker, Arizona (includes Riverside, California Indian School Health Center and Peach Springs Health Center)
>
> The magnitude of mental health problems is not adequately reflected in our data collection system. At Parker acute and chronic alcoholism is a significant problem on reservations, accounting for accidents, arrests, broken families, loss of job, nutritional and liver deficiencies. Records of arrest do not show an increase of young people involved; however, the morbidity in young people under the influence of alcohol seems to be increasing. Mental health services in general are inadequate. Since Parker has no social worker, patients are sent to Phoenix for social and psychiatric evaluations. AA programs have been attempted on several occasions to date by non-Indians from the Parker community but these have generally been unsuccessful. There seems to be a strong need for good community organization to gain support for any mental health program.

A similar situation exists at Peach Springs. Alcoholism, depressive neurosis and character disorders represent the three most important mental health problems existing with the unit. A general review of charts reveals that probably 50% of the overall population, including teenagers, have definite drinking problems. Probably 90% of the population over 25 years of age fall in this category. There is a BIA social worker assigned to the Peach Springs area but headway is slow in finding solutions to these problems. Throughout the year several suicide attempts occur, usually surrounding situational depression.

Probably less than 10 out of 300 known problem drinkers receive any form of counseling. Probably out of 20 to 25 people with mental illness, with the exception of alcoholism, only a very few receive any type of psychosocial follow-up. About 75% receive initial psychosocial evaluation but, due to the great distance necessary to be traveled in order to obtain further psychiatric help, few people avail themselves of such services. Due to the overall socio-economic conditions present within the community, probably 25 children can be considered as seriously disturbed. At present there are approximately 15 mentally retarded individuals within the community and of these 30% received diagnostic evaluation, treatment and rehabilitation at the Health Center.

Community Education workshops are planned by the health staff for F.Y. 1969, aimed at adult and teenage groups in an effort to provide general education in relation to the field of mental health. Negotiations are underway to utilize State Mental Health Clinics in Prescott and Flaggstaff. Although these clinics are still quite a distance from Peach Springs, they are far more accessible than Phoenix. A small number of selected problem drinkers are seen regularly at the Health Center for supportive therapy and often Disulfiram.

Sherman Institute at Riverside, California, is served administratively by the Colorado River Service Unit, mental health services are still in the developing stage. Dr. D.G. Zappella, Psychiatrist for Tri-City Mental Health Authority, Pomona, California, is providing consultation and assistance to the BIA and DIH personnel who are concerned with the general health and welfare of the students at Sherman Institute. Dr. Zappella's services are available two days per month. In addition, this year Mr. Paul Gedansky, Psychologist, has been contracted to provide counseling and psychological testing services to the school. For students having acute psychiatric problems needing psychiatric hospitalization, care is provided by Dr. John F. McMullin, Psychiatrist, Riverside General Hospital.

Inservice training has been arranged through 89-10 funds to the counseling staff by Drs. Brockman and Bates of California State College. The overall result has been quite good in terms of improved staff morale and improvement of services to the students. Much work needs to be done and proposals have been sent for funding a bona fide mental health team, including one half-time Psychiatrist, one full-time Psychologist, one full-time Psychiatric Social Worker, and supporting clerical staff.

A Mental Health workshop is planned for August 1968, and plans are to develop these into Area-wide School Mental Health workshops to be held at Various Indian Boarding Schools three times a year.

Fort Yuma Service Unit

Although mental illness has a Q value* of 119 and mortality* of 23.7 for fiscal year 1968, these problems affect a considerable portion of the families serviced by the Fort Yuma Service Unit. Morbidity, as seen on a day-to-day basis in the clinics, is considerably higher than the figures indicate. The service unit staff enumerate the following factors contributing to poor mental health on this reservation:

1. Long history of family deterioration, with emotional, cultural, and economic deprivation of children.
2. Little opportunity for youths and young adults to gradually assume adult responsibility.
3. Lack of skills and opportunities for satisfying work.
4. Frequent stresses or crises with which family members are unable to cope (e.g., much violence, alcoholism, severe injuries, extended incarceration, etc.). The general low standard of living, lack of utilization of prenatal and well-baby facilities, and poor nutrition also contribute to this problem.

Individuals are selectively referred to the contract psychiatric consultant in Phoenix as needed. Some referrals are made to the Imperial County visiting psychiatrist when indicated. A guidance and counseling component has been operating under the Ft. Yuma Community Action Programs for several years to assist Indian students with school problems. The PHS Community Health Education Specialist who also is a social worker has, on referral, provided social casework counseling to a number of Indian beneficiaries when indicated in regard to mental health problems.

A State Mental Health Clinic is currently in operation as a cooperative effort of the Yuma community. It is hoped that this will develop into a useful resource for the reservation residents.

The general feeling of the DIH staff at Ft. Yuma and the Tribal leaders is that the ultimate answer to much of the mental health concerns appears to be in the gradual improvement of living standards and education of the beneficiary population.

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*NOTE: These are not standard epidemiological terms and the contract staff has not been able to secure a translation of them. CLA & MB

A small-scale but expanding alcoholism rehabilitation program sponsored by the Ft. Yuma Community Action Program, with technical advice and assistance of the PHS staff and its facilities, has been in operation over a year. This voluntary alcoholic rehabilitation work project is still awaiting OEO funding. PHS participation has been in planning the program, medical evaluation, treatment, and supervision of participants, and selective administration of antabuse. The PHS Community Education Specialist is one of four local professionals who assist in the capacity of counselor to the participants. The project evolved from the Ft. Yuma Council on Alcoholism which is composed of representatives of PHS, CAP, Tribal representatives, and Methodist and Catholic Clergy.

It is not clear how the programs at Parker and Fort Yuma have evolved since this early report. Irene Sharkey of Fort Yuma was recruited and trained as a Mental Health Technician in 1971, and a local psychiatric consultant has been utilized on a contract basis for both Service Units. The Health Center at Peach Springs, which is grouped with these administratively, contracts with the Mohave Mental Health Center at Kingman, Arizona for Mental Health services. There were indications in 1974 of increasing interest in evolving a regional Mental Health Program for far western Arizona and eastern California, both among tribal representatives and in some IHS discussions. However, nothing tangible was reported during the development of this report.

2. Sherman BIA Indian School -- Riverside, California

Since 1970 a full-time consultant in mental health has been provided to Sherman Indian School in Riverside, California. This program seems to have strong administrative support from the BIA staff and is able to provide individual and group therapy for students and inservice training meetings with staff. However, no detailed reports on the program were made available. Hence it was not possible to compare this program with others in BIA school settings.

H. City of Phoenix

The hub for all of these programs is not only the Area Office but also the Phoenix Indian Medical Center. Ms. Marjorie Myren is Chief of the Area Office Mental Health Programs, as was described earlier. She functions not only in an administrative relationship but as a consultant on program development to all the Mental Health consultants and contract staff. Daniel Brown, a psychologist, and other supportive staff also function in program planning and development and as resource personnel for the Service Unit level programs.

Within a short distance of the Area Office are both the Phoenix Indian School, and the Phoenix Indian Medical Center -- a large specialty hospital. Both have active mental health programs and staff. The outlines of activities at the Phoenix Service Unit level drawn up in 1968 are quoted below.

For a number of years the Phoenix Service Unit has had a 4-phase program in care, management and prevention of mental illness. First phase, hospitalization is provided for the acutely mentally ill and the alcoholic who is in physical or mental difficulty. The choice of hospital is determined on an individual basis. Camelback Hospital, a private psychiatric hospital, is used usually for those patients who have no record of previous psychiatric hospitalization, or who have been hospitalized but are not considered chronically disturbed. It is through the Phoenix Service Unit that all of the other service units in the Area arrange for psychiatric evaluations and hospitalization.

A DIH contract psychiatrist, usually Dr. Otto L. Bendheim or Dr. James M. Kilgore, Jr., provides direct service and consultation. Throughout this phase of care, PHS staff continue to give social service, public health nursing, medical and surgical supervision and to work with the family and community. The Area Psychiatrist is also available on an emergency basis, time permitting, for evaluation on an in- or out-patient basis.

The second phase is the outpatient mental hygiene clinic which utilizes time purchased by DIH from a private psychiatrist. Sixteen hours a week are purchased in block time from Dr. Kilgore and about five or six hours of this time is spent at the Phoenix Indian Boarding School. Formerly, one hour a month was directed to consultation with the school administrative staff, and one hour a week in group sessions with the school staff involved in the care and discipline of students. However, this year a School Mental Health Committee has been organized and is currently intensely engaged in revamping the entire mental health program of the school. Plans involve establishment of a full mental health team, in-service training of all school staff and curriculum changes in keeping with the special needs of the Indian students.

The Deputy Director of Social Service and two graduate students in Social Service administration continue to work with Dr. Kilgore to increase the number of students given service. The major goal of this program is to enable disturbed students to remain in school and mature.

The other 12 hours a week are devoted to psychiatric consultation and psychotherapy to individuals and families. The referrals are made by a physician through the Social Service Department. The Social Service staff has responsibility for the development of social history and abstraction of medical facts significant to the case, to orient the patient to the service offered, and to help minimize all problems involved with families and community. The 16 hours mentioned above and all the preparation and follow-up is called Family Clinic.

The third phase of the mental health program is still not a clearly defined component but through mutual understanding and improved communications and meaningful intervention, the physician, social workers and public health nurses become aware of the emotionally disturbed patients and provide supportive therapy on a structured or crisis basis. Many of these patients have been mentally ill and in time of crisis psychiatric consultation is obtained. For example, monthly meetings (called problem family conferences) of the pediatric staff with the social workers, public health nurses or area psychiatrist are an effort to better understand certain families and to coordinate efforts to help families resolve problems.

The fourth phase of the mental health program is the supervision, consultation and management of chronic mentally ill patients who are in the community or in nursing homes. When the patient is in the home, efforts are made to prevent further breakdown of family life and to gain understanding and acceptance of the patient. During the past year the area psychiatrist, health educator and field health officer have been working closely with the Salt River Tribal Health Committee in organizing a community mental health program.

In terms of the problems of mental retardation, a cooperative program with the pediatric staff has been started which focuses on early identification of the mentally retarded child and realistic planning with the family. This is a cooperative venture with BIA and the county welfare department. The greatest number of referrals for psychological testing, pediatric evaluation and social service consultation on the trainable children come from the schools and the Head Start program. Psychological testing is provided by the DIH contract program.

Acute and chronic alcoholics are provided with hospitalization and medical supervision as an integral part of a comprehensive medical program. Casework services, referrals for vocational rehabilitation and Alcoholics Anonymous are utilized when indicated. A community-based alcohol program has not as yet come into existence.

1. Phoenix Indian Medical Center

From these beginnings, with collaboration of the Social Service Branch, a full-time outpatient program has been developed at the Phoenix Indian Medical Center with a staff of two social workers and a psychiatrist. These see referrals from IHS physicians within the hospital as well as Indian persons who present themselves from the Phoenix metropolitan area or who are referred in from outlying reservations. They also handle much

of the family contact work around nursing home placements and other special programs for Indians living at a distance, and help coordinate these activities with the on-reservation staffs.

There is some planning being projected toward the development of an inpatient facility for psychiatric hospitalization within the IHS hospital. However, at the present time both the state hospital systems and a private psychiatric hospital (Camelback) are used where hospitalization is needed. This has worked out farily well, particularly for verbally acculturated Indian persons or where short term hospitalizations are indicated. Longer term commitments sometimes pose problems, and for some chronic psychotics a nursing home placement with psychiatric consultation still seems the best solution.

2. Phoenix Indian School

Dr. Carl Hammerschlag spends half-time in the Phoenix Indian School, seeing individual students, conducting group therapy sessions, and working with staff and faculty. He also supervises the work of a number of graduate students in counseling who extend the range of services available to the school. The other half of his time is divided between the Phoenix Indian Medical Center clinic and consultation to tribal and Service Unit programs where he emphasizes community program development rather than merely delivering direct clinical services. However, he is available to IHS Mental Health staff to consult over problems of patient diagnosis and thereapy as is Dr. Thomas Bittaker, a full-time IHS psychiatrist in the Phoenix Medical Center.

From his entry into the IHS Mental Health Program in the Phoenix Area in 1970, Carl Hammerschlag, M.D., has spent a significant portion of his time working with the students and staff of the BIA School at Phoenix. This is one of the older well-established schools, and its subtle influence on the developing city is noted by observing that what is now a main traffic artery is called Indian School Road.

The Phoenix Indian School provides a basic suite of offices for Dr. Hammerschlag from which he sees students and staff, and also supervises interns in psychology from nearby graduate academic programs.

Much of Dr. Hammerschlag's work in the school setting has focused on group work with students and application of systems theory principles to an analysis of the school and the BIA setting. As well, he uses similar approaches to demystify stereotypes concerning American Indian personal interactions. Dr. Hammerschlag has presented a number of papers at professional meetings on these subjects, among them are the following: "Indian Education: Human Systems Analysis," by Hammerschlag, Alderfer, Berg; "Group Relation and Expression of Aggression," by Alderfer, Hammerschlag, Berg, Fisher; "Identity Groups with American Indian Adolescents," Hammerschlag; "'T' Groups with American Indian Adolescents," Hammerschlag.

3. Dr. Hammerschlag as Consultant to Service Units

In addition to these more formal presentations Dr. Hammerschlag has organized panels of Indian paraprofessionals and tribal youth who have presented their problems and points of view at national meetings of both the American Psychiatric Association and the American Orthopsychiatric Association. He has assumed leadership of a study group on issues relevant to

American Indian social problems composed of members of the American Orthopsychiatric Association.

These activities involving tribal personnel seem to grow naturally out of Dr. Hammerschlag's interest in youth, both in the Phoenix School and in its recent graduates as they enter into further training or return to their reservations. He combines the school activities with an active part-time assignment as consultant to a number of Service Units and tribes within fairly close travel distance of Phoenix. The emphasis of these consultations appears to be less of a clinical nature than in community organization and preventative programs.

From time to time, however, he is withdrawn from travelling consultation to the Phoenix Medical Center, which has an ever-expanding program. There his role is more clinical in nature, but his first hand knowledge of the situations "back home" on many reservations, as well as his acquaintance with personalities and agency resources, are often useful.

4. Relationships with the Phoenix Area Office

As was described earlier, the Phoenix Area Offices are entirely administrative and are physically separated from both the Phoenix Indian Medical Center and the Phoenix Indian School. Dr. Bittaker and his staff, and Dr. Hammerschlag and his activities, offer separate service delivery programs in a quite autonomous fashion. Their proximity to the Area Office does allow easier access and more frequent interaction than can be arranged for staff in the outlying Service Units with whom they are equated in organization tables. Perhaps because of this, and perhaps because the institutions in which they are located serve populations from many parts of the Area, both are considered by many persons, within and outside of IHS, as representatives and auxilliaries of the Area Office.

VI. SUMMARY -- PHOENIX AREA

A. Problems Yet to be Solved

1. The staff at the local level all seemed spread much too thin to perform adequate services of both a clinical and consultative type. On larger reservations one or two Mental Health Technicians is not sufficient to provide coverage of all the villages scattered over many square miles, and the professional staff are not able to travel and still be available for clinic appointments and consultations to focal agencies and tribal officials.

2. One of the Phoenix professional staff seems particularly able to elicit the gestures toward self-determined operations and defiance of federal paternalism, but lacks the ability to provide long term support either within IHS or at the tribal level. This tends to abort the development of the necessary training, skills, and growth experiences to turn these gestures into realistic local control. There is danger that on occasion defiance of the "parental" authorities may backfire and leave local Indian populations more discouraged than ever if their ventures are not successful. A balance is needed, tipped toward local control, but with sufficient loading to prevent runaway escalations and oscillations.

3. The closedness of IHS and other federal agency staffs in their social and workaday activities may be accepted by most Indian populations, but it cuts the Mental Health professional staff off from a true sense of the culture and life of the people they are serving. Too heavy reliance on paraprofessional staff to make the bridges between professionals and clientele is not always fair or effective. Particularly, the lack of

adequate housing and amenities that would make it possible for families of professionals to live on the reservation, together with the attractiveness of commuting from larger cities and suburbs, combine to keep IHS staff isolated. This tends to make Mental Health staff more removed from the tribal communities and less intimately familiar with local resources than may be desirable. This characteristic is found in many IHS Areas but is pronounced in the Arizona settings of the Phoenix Area, with the possible exception of the San Carlos Apache Reservation.

4. A real need for direct clinical services in addition to consultation often creates conflicts since staff has largely been selected with consultative and administrative skills as a priority. Achieving a balance becomes something to be attained over time.

5. The vast distances involved are a factor in the development and staffing of programs. Those programs closest to Phoenix seem to operate with more support and access to consultation within IHS, while those at a greater distance seem to have a smaller percentage of professional personnel and less on-the-spot consultation and administrative guidance. The Area Chief does visit all the Service Units, but those at distant and inacessible points are in contact relatively infrequently. Area-wide planning and training sessions have not been a frequent occurrence in recent years.

6. The budget seems to be bent and stretched to fit rather than being planned with needs and priorities in mind and then shaped to accomplish them. This is endemic to all IHS Areas, but seems particularly evident in the Phoenix Area since there are many more goals and objectives and desired programs than are implemented.

B. Accomplishments

1. A full-time administrative Chief, rather than one that divides energies and attentions between Area administration and clinical service delivery.

2. Each of the large reservations has a nucleus of a Mental Health Program, either based within IHS or with an IHS contribution of funds to staff based in tribal and state agencies.

3. Program development and planning with other IHS branches at the Area Office level seems to proceed well and with more cordiality than in most Area Offices.

4. At the Service Unit level the SUD's seem to be able to speak highly of the programs and to include them objectively in their reports and thinking.

5. Consultant fees on a parity with medical specialist fees have been established for Medicine Men and traditional healers where these persons can be locally identified and in those instances where clientele of IHS Mental Health Programs desire to utilize them.

6. Training programs have been established and supported at Desert Willow Training Center so that most if not all Mental Health Technicians will be able to achieve an Associate of Arts degree through Arizona institutions. Specialized field experiences tailor-made to suit the needs of both the tribes and the students have also been established. Area staff participate not only as preceptors but also in teaching some of the didactic material.

7. The Area Chief has a sense of responsibility for training that extends beyond the Desert Willow Training Center to include inservice opportunities at all levels of staffing. There is also support for active involvement in community and inter-agency consultation and education activities.

8. A decentralized program seems to be achieved, with administrative and professional consultation made available without sacrificing local autonomy.

VII. THE TUCSON SUB-AREA

Tucson is the second largest city in Arizona and the fastest growing metropolitan area in that state. Located in South central Arizona, it has a long history of association with the Spanish and Mexican explorers and settlers, for whom its surrounding mountains formed a natural stopping place punctuating the Sonoran deserts. To the west of Tucson lies the Papago Reservation, covering an expanse equal in size to the state of Connecticut, and served by an IHS Hospital at Sells. There are a couple of additional pockets of Papago land and population near Tucson itself, and on one of these surrounding San Xavier Mission are located the offices of the IHS Office of Research and Development, with its associated Desert Willow Training Center.

This Papago Reservation complex is the site of innovative service delivery techniques and systematic efforts to combine tribal traditions and space age technology in the solution of rural health problems. Because of its unique characteristics it has only liaison and neighborly relationships with the Phoenix Area and is administered as a separate entity sometimes designated as the Tucson Sub-Area.

The Papago Reservation and its culture are well described in a report prepared by the Papago Planning Department.

A. Description of Papago Reservation

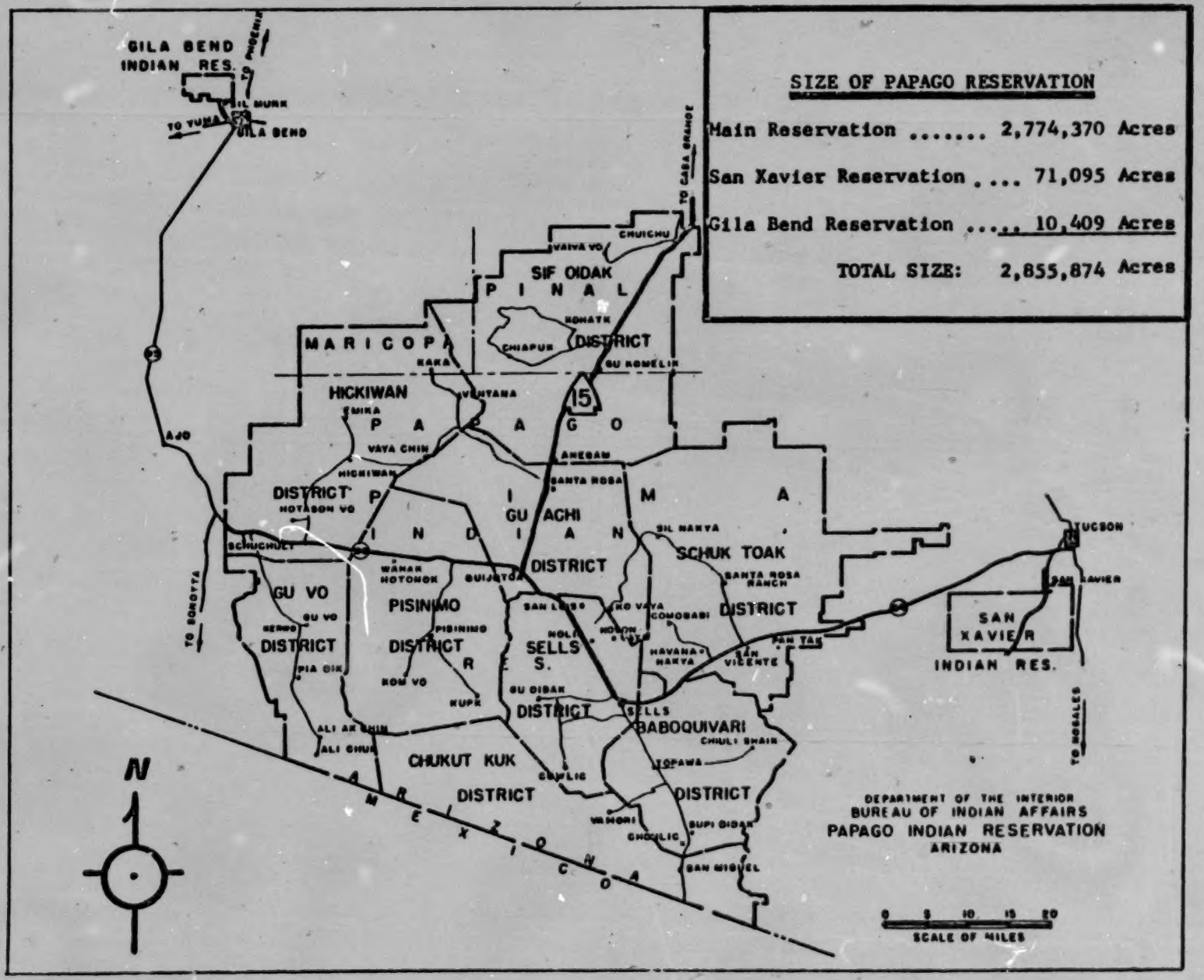
Reservation, Terrain and People

The Papago reservation lands lie in the Sonoran Desert and consist of wide arid valleys and plains interspersed with mountain ranges which rise abruptly from the valley floors. The elevation varies from 1,378 feet on the northern boundary in the Santa Rosa Valley to 7,730 feet on Baboquivari Peak on the eastern boundary. The valleys range from 1,378 feet to above 3,000 feet in elevation and the mountains generally rise about 2,000 feet above the valley floors.

Average mean temperature in Sells (elevation: 2,360 feet) is 68 degrees. The maximum temperatures recorded as 116 degrees and the minimum was 16 degrees, Rainfall varies from an average of six inches per year on the northern and western portions of the reservation to 20 inches per year in the vicinity of Baboquivari Peak on the eastern side. Average mean precipitation at Sells is 11.4 inches. Snow falls occasionally in the higher mountains during the months of January through mid-April, but, generally melts in several days. There are no live streams traversing the reservations. Humidity is generally very low except during the summer rainy season (July and August). Humidity then rises quite sharply.

The vegetation is typical of the southern desert shrub region with the dominant shrub being creosote bush. Associated species are the various cacti, bursage and burroweed. The bottom lands and plains are characterized by common mesquite and screwpod mesquite with annual gramas and three-awns or saltbrush in areas of saline soil. In the foothills and mountainous areas with higher rainfall, the various perennial grasses and curley mesquite are found with traces of other grasses typical of the high desert.

Wildlife on the reservation includes mountain sheep, desert mule-deer, whitetail deer, javelina, antelope, jackrabbit, gambels quail, and doves. Predators are the coyote, bobcat, fox and an occasional mountain lion.


SIZE OF PAPAGO RESERVATION
Main Reservation ..... 2,774,370 Acres
San Xavier Reservation .... 71,095 Acres
Gila Bend Reservation ..... 10,409 Acres
TOTAL SIZE: 2,855,874 Acres
GILA BEND INDIAN RES.
TO PHOENIX
TO YUMA
GILA BEND
CASA GRANDE
MARICOPA
PINAL
SIF OIDAK DISTRICT
HICKIWAN DISTRICT
PAPAGO INDIAN
GU ACHI DISTRICT
SCHUK TOAK DISTRICT
GU VO DISTRICT
PISINIMO DISTRICT
SELLS
BABOQUIVARI DISTRICT
CHUKUT KUK DISTRICT
SAN XAVIER INDIAN RES.
TUCSON
TO SOMOTTA
TO NOGALES
AMERICA MEXICO
N
DEPARTMENT OF THE INTERIOR
BUREAU OF INDIAN AFFAIRS
PAPAGO INDIAN RESERVATION
ARIZONA
SCALE OF MILES

The Papago Tribe and its History[1]

For centuries the Papagos have lived in the many valleys crossing what is now the International Boundary between the State of Arizona, USA and Sonora, Mexico. At the time of the first visit by Europeans, the Papago homeland — then and now known as "Papagueria" — extended from the Gulf of California east of the San Pedro river and into northern Mexico. The United States portion of this territory would roughly be founded by the present day towns of Yuma, Gila Bend, Casa Grande, Tucson and Nogales.

The Papago Indians are members of the Piman family, racially distinct from the other Indian groups of the United States. Linguistically, the Papago dialects still spoken in a majority of Papago homes are classified with the Pima-Papago division of the Piman Language. The latter is a subdivision of the Uto-Aztecan linguist stock, which is made up of Indian languages spoken from southern Mexico to the borders of Montana and Wyoming. Culturally, the Papagos are related to the desert tribes of north-western Mexico, western Arizona, southern California and Nevada.

The first important contact between Papagos and Europeans came when Father Eusebio Kino, the missionary-explorer started his missionary program in the late 1600's and early 1700's. Father Kino found the Papagos to be a peaceful people with permanent homes and farmlands. The Papagos were settled throughout the "Papagueria" in numerous small agricultural villages. The Papago villages were usually automonous.

Village leadership was more through the personal influence and character of the headman, the vested authority. In addition to the headman, each village also had a council of elders, a village crier, a keeper of the smoke, and other village officers who were in charge of ceremonies and festivals. Papago warfare, led by men selected for their ability, was directed against the Apache Tribes to the east.

Typically the Papago family was made up of the parents, their children and the wives and children of the sons. Such units were grouped into villages with a tendency for village members to be related through the paternal line. Like other southern and western groups, the family was the important social and economic unit. Each family was responsible for its own subsistence.

Papago religious practices mainly related to the annual cycle of nature. Two of the most important annual events was a rain ceremony in early summer and a deer dance in the autumn or early winter. In addition to the annual rituals, there were many curing and personal crisis ceremonials.

The reports of the past give the impression that the Papago people led an unhurried, relaxed type of life, with a dependence upon established tradition and upon the old people who understood this tradition, rather than upon individual success and emphasizing cooperation and involvement.

[1]This material was adapted from facts about the Papago Indian Reservation and the Papago People published by the Bureau of Indian Affairs in 1972.

During the summer months the Papagos established camps in the mountanious regions of the "Papagueria" to hunt wild game and gather mesquite beans and others plants. The semi-annual movement between summer and winter quarters was a fixed event in the Papago way of life.

The principal Papago crops were corn, beans, and squash, to which the Spanish missionaries added wheat, kidney beans, lentils, vetch, chick peas, and possibly watermelons. Wheat could be planted in February and harvested in May, and corn was regularly planted in July or August when summer rains came. This permitted two grain crops annually, although the extreme variation and scarcity of rainfall limited the potential.

Economy and Income

The pre-Spanish Papago economy was one of limited irrigated farming and the gathering of wild food products. Papago agricultural techniques were simple. Most fields were small, located at the foot of steep slopes in order to capture the runoff from desert rain storms. Thus, small cultivated areas could be watered, if rain came in the adjacent hills at the right time. Along the Santa Cruz River, in the vicinity of the San Xavier Mission south of Tucson, extensive irrigation canals effectively supported the largest single concentration of Papagos within the region.

In the late 1600's the Papago economy underwent a great change due to the introduction of cattle and horses. Father Kino had stock from the missions of Sonora driven north and cattle and horses quickly became established in many areas of the "Papagueria". Unfortunately for the Papagos, the Apache in the mountainous areas to the north and east found Papago stock a strong lure for increased raiding activities. Since the Apaches also had acquired horses they could travel far and fast. Expanding Apache raids forced the Papagos to defend themselves by means of more carefully organized military activities than had previously been common. Despite the Apache problem, cattle and horses brought the Papagos a greatly increased meat supply and increased mobility.

For many years, the Papago Tribe has ranked among the lowest in income of any tribe in the Southwest. The principal livelihood in the reservation is cattle raising. Livestock were introduced by the Spaniards around 1700, but the herds have remained relatively small due to the general lack of natural surface water and the sparse vegetation cover which is typical of this Sonora Desert region. The Bureau of Indian Affairs began the drilling of water wells and construction of dams and charcos (water collection pits) during the Civilian Conservation Corps days of the 1930's. Since that time, an extensive water development and maintenance program has been carried out on the reservation to support the cattle enterprise there. Most of the reservation is now

used for rangeland, a square mile of natural forage supporting less than three head of livestock per year. However, stock water is being increased by adding new wells and improving water catchment structures on the reservation. Also, new clearing and seeding techniques now being used hold promise for upgrading range capacity. Cattle land management instruction and training are regularly provided in summer youth camp and at special agricultural courses.

The tribe collectively owns a small registered herd of Hereford cattle which is under professional management. Two specially seeded pastures are used to support the herd. By selective purchase and rotation of quality bulls, both the tribal herd and privately owned herds on the reservation are constantly being improved.

Generally, there is no extensive farming due to lack of an adequate water supply. Some of the Papagos do have small garden plots on which they raise native corn, beans, and other vegetables depending upon run-off water from washes during the rainy season for moisture. Approximately 1200 acres of irrigated land have been developed at San Xavier where the water table is relatively shallow and a system of electrically powered wells has been installed.

The Papago Indians are now entering a new stage in their development progress. Two large mining companies, Hecla and Newmont, have each discovered significant deposits of high grade copper ore in the northern part of the reservation and are now preparing for full-mining operations there. Training of Papagos for this kind of employment has begun and several hundred individuals will eventually be hired as regular full-time workers receiving full-scale wages. A third mining company — American Smelting & Refining — has begun copper mining operations at San Xavier near Tucson.

More jobs and land lease income will be generated by the start-up of the San Xavier Industrial Park in 1972. Funded by a loan/grant from the Economic Development Administration, the 40-acre park is expected to quickly attract several light industries to the San Xavier Reservation. Additional industrial acreage will be developed at San Xavier to match demand.

A planned earth dam and reservoir, to be built by the Corp of Engineers, is in progress. The project will provide run-off control and a means to irrigate many thousands of acreas in the north section of the main reservation. Campgrounds, fishing, and a recreational park are being planned in conjuction with this water project.

Old traditional skills, however, are still being practiced among the Papagos. Interest in the famous Papago baskets has increased to the extent that nearly 3000 are marketed annually through the tribal arts and crafts program, at rodeos, crafts shows, county and state fairs.

Villages and Settlements

Some 149 separate and distinct locations on the main reservation have been identified as settlements. Of the 149 settlements, 74 are currently inhabited. Nine of the communities are considered as major villages with populations of more than 100. The major villages included Ali Chukson, Topawa, Covered Wells, Santa Rosa, Gu Vo, Pisinimo, Gu Oidak, Sells and Chui Chu.

State Highway 86, an all-weather hard surface throughfare, connects Sells with Tucson, a distance of 61 miles to the east and with Ajo, a distance of 71 miles to the west affording easy access to points beyond these cities. A paved highway runs north to Casa Grande and Phoenix.

A road program is presently in existence to pave 64 miles of the reservation roads during 1973. Additional plans call for a total of 185 miles of road paving over the next three year period.

There are about 980 houses on the reservation but almost 65% of these are considered below minimum standards. Many of the houses are built of sun dried mud adobe which is vulnerable to hard rains that last for 48 hours or longer. The side walls and roof will often erode and collapse under such conditions.

The BIA and the Papago Housing Authority in cooperation with HUD are providing modern housing on the reservation. Presently, 87 new houses have been constructed, 110 are in progress, and a total of 500 units are planned by 1975.

Education

It was not until 1917 that the first federal school was established on the main reservation at Sells and it was not until after 1917 that any attempt was made to develop Papago resources. Education facilities are provided on the reservation by public, parochial, and Federal Government schools. The Sells Public School (Indian Oasis District No, 40) offers elementary and secondary education. The Federal Government provides elementary education at day schools in three isolated villages and a bording day school near Santa Rosa Village. Four parochial schools are maintained by the Franciscan Order. High school education is also available at Federal Indian schools throughout the country. Some students attend public high schools in Tucson or Catholic high schools such as St. Johns at Laveen, Arizona. Adult education classes are conducted in several villages through the cooperative efforts of the tribal government, the Office of Economic Opportunity and the Bureau of Indian Affairs. Construction of a new public high school at Sells was completed in late 1970 and a new BIA elementary boarding day school is now being planned for San Simon about 30 miles west of Sells.

Traditional Decision Making Role — Establishment and Description of the Papago Tribal Council

A long time ago the villages had chiefs. These chiefs were always men. The chiefs were selected by the people according to their ability to be a leader. The qualities of a "leader" were not necessarily or consciously stated. But, here are some considerations that probably were taken into account. A leader was somebody people respected, someone dependable, a person that would come forth for the people and would know he was representing all of the people. When there was a problem in the village, the chief got together with the people and called a meeting. Usually the problem was related to an environmental condition. For instance, if a person needed help on their farm, the village was called together and they offered to help. In exchange for this help the person would share the crops with the people who helped. If the problem was because of the environment or a condition where the harmony was disrupted, then the village participated in a ceremony held by medicine men that would be for the purpose of restoring the environment back to its harmony. After the village and chief got together about a particular problem, a decision was made as to how the problem would be resolved; who in the village would be needed to solve the problem; and what tasks or responsibilities the individuals would carry out to help resolve the problem. When the problem was bigger than that village could handle or if the problem involved other villages then, "runners" who acted as messengers were dispatched to notify the other village chiefs and people. Then the chiefs assembled and discussed the problem. When a decision was reached and plans made, the chiefs returned back to their villages and informed the village of the plan.

For a serious problem, the chiefs fasted (and only smoked) during the time of decision making until a decision was reached.

The chiefs were very cautious when making a decision because they did not wish to offend anyone in the process. The problem was resolved, but it was extremely important to have solutions that would avoid consciously offending anyone.

Once a plan evolved, the particular individual with certain skills would do their part of whatever projects was implemented. For example, if there was dance or feast, several things had to be arranged - a cow was usually slaughtered. Those members of the village who were knowledgeable about livestock would select and slaughter the cow. A woman having overall experiences in cooking would be selected to serve as head cook. Wood gathering, repairing the feast house and many other tasks were done by those people who were experienced in this. All was done in a cooperative, voluntary fashion as a group and tasks were accomplished completely with full participation.

This is the traditional way Papago people governed themselves and made decisions.

With Spanish exploration and occupation of the New World, the Papagos came under the rule of the Spanish crown. As subjects of the King of Spain they received full citizenship and a large measure of local self-government. However, except through missionary activities, most Papagos remained isolated from Spanish contact. In 1812, Mexico declared itself independent from Spain and until 1853 the major portion of the "Papagueria" was under the political jurisdiction of Mexico. During the period of Mexican rule, the Papagos continued to remain isolated, with little governmental contact.

In 1853 the Gadsden Purchase added the lands south of the Gila River to the United States. This resulted in the Papago Indians coming under the political jurisdiction and protection of the United States. At the time of the Gadsden Purchase, the land of the "Papagueria" was considered available for non-Indian settlement, and many springs, wells and grazing areas were soon claimed by ranchers moving into the area. Little was done to secure land for the exclusive use of the Papagos until July 1, 1874, when a reservation of about 70,000 acres was established by Executive Order near the San Xavier Mission.

The second reservation for Papago Indians was established at Gila Bend on December 12, 1882. An Executive Order of June 16, 1911, established small reserves of 80 acres each at Indian Oasis (now Sells) and San Miguel. Four Executive Orders of May 28, 1912, established the Maricipa, Cockleburr, Chui Chu and Tat-murl-ma-kutt reservations.

An Executive Order of December 5, 1912, added another reservation at the foot of Baboquivari Peak -- Santiergos. An Executive Order of January 14, 1916, established the "Sells", Nomadic Papago, or Papago Villages Reservation which included the area formerly within the Cockleburr, Chui Chu, and Tat-murl-ma-kutt land (the Maricopa Reservation became a part of the Pima Indian Reservation). Congressional Acts in 1926, 1931, 1937, and 1940 authorized the purchase of patented land to be added to the Papago Reservations in addition to inclusion of public domain land.

The net result of the various Executive Orders and Acts is a land area totaling 2,885,874 acrea being reserved for the use of the Papago Tribe. This consists of 2,774,370 acres within the present Sells Reservation, 71,095 acres within the San Xavier Reservation and 10,409 acres within the Gila Bend Reservation. Little change of any importance in Papago land holdings has been made since 1940's, but a very important change in the nature of Indian title came about in 1955 when, by Act of Congress, the Papagos were given all mineral, as well as surface rights to the reservations.

With the Indian Reorganization Act of 1936 which was ratified in 1937 by the Secretary of Interior, the Papago Tribal Council as a form of government was established.

The basic political document governing the Papago Tribe is the Constitution and By Laws of the Papago Tribe of Arizona, ratified by the tribal members on December 12, 1937. The governing body of the tribe is an elected tribal council consisting of twenty-two members. Regular council meetings are held each month. The council is presided over by a chairman selected by the council members. Other tribal officials included a vice-chairman, a secretary, and a treasurer. For purposes of tribal administration, the reservation is divided into eleven districts - Baboquivari, Chukut Kuk, Gu Achi, Gu Vo, Hickiwan, Pisinimo, Schuk Toak, Sells and Sif Oidak. The non-continuous Gila Bend and San Xavier districts bring the total to eleven. Each district is a local governing body, selects its own local council and elects two delegates to the tribal council. Issues raised at council meetings are carried back to district and village meetings for the people to reflect upon. When consensus is felt, that is transmitted back to council.

B. The Office of Research and Development

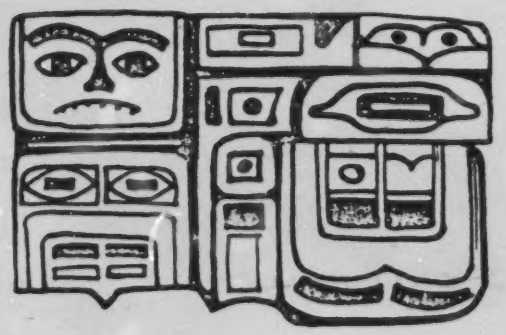
1. Overview

The following two pages describe the mission and organization of the Office of Research and Development, headed by Eugene Rabeau, M.D., a former Director of IHS. They are taken from a report prepared for IHS in 1972, and available in complete form from OSRD, P. O. Box 11340, Tucson, Arizona 85706.

INTRODUCTION

The Indian Health Service was organized in 1955. Initial priority was placed on overcoming critical staff shortages and facility deficiencies. By the early 60's substantial gains had been made. While the initial thrust was to expand provision of services and facilities, this was done within the framework of a mission which was and is, "to raise the health status of the American Indian and Alaskan Natives to the highest possible level." This mission implies a conscious effort not just to provide services, but to provide services with the maximum possible impact on the health of the people. It became increasingly apparent, however, that staff and facility resources would never be adequate to fully meet Indian Health needs if the delivery of health services continued to be based on traditional organizational patterns in the health field. This awareness brought about expanded efforts to improve the organization and management of health resources. Experience had also concluvisely revealed that the effectiveness of health programs is directly related to the amount and type of involvement on the part of the health services consumer - the Indian people.

Centers for Training and Health Program Systems Development were established in Tucson, Arizona in 1966 for the purpose of increasing health resource efficiency and effectiveness and Indian involvement. To further accelerate achievement of these goals, the Office of Program Development was created in July 1969, bringing together within one organizational structure the Health Program Systems Center (HPSC) and the Desert Willow Training Center (DWTC).



In March, 1971, the organizational statement of the Indian Health Service was amended to provide a more accurate description of current organizational structure, philosophy, and functions. Within this reorganization, the Office of Program Development became the Office of Research and Development, and "as staff resource for the Service Director: (1) develops and demonstrates new methods and techniques for Indian community participation in, and management of their health program; (2) provides consultation and technical assistance to all operating and management levels of the Indian Health Service and Indian tribes in the evaluation, design and implementation of health management and services delivery systems; (3) coordinates health research and development activities within the Service directed to the improvement of the health of the Indian people."

The mission of the Office of Research and Development is to develop a systems approach to the delivery of health services. The overall health system will be composed of a number of subsystems and will be designed to make possible the following:

a) Integration of available medical treatment and prevention services required to meet the needs as identified by a consumer group.
b) Coordination of health services by the Indian people with all other community activities (education, economic development, housing, nutrition, and communications) so they can develop a concerted and balanced drive toward their objectives.

Develop human resources by providing training and related experiences to health staff and the Indian people. Human resource development has a dual focus:

a) provide and increase technical competency
b) accelerate the transition of program decision making from health professionals to Indian community residents.

Demonstrate the development process, both human and systems, within the Sells Health Delivery System, and the integration of health services into overall tribal operations.

The Office of Research and Development, therefore, is dedicated to the development of an approach that will incorporate health sciences, systems technology, and community development principles into a unified and dynamic force.

THE FUNCTIONAL ORGANIZATION

The organization of the Office of Research and Development is a functional or operational reflection of its mission statement.

A. There are three major components of ORD that are staffed and funded for the express purpose of "production" in the form of:
   1. the delivery of medical and related health services for a specific population group (Sells Service Unit),
   2. the training of Tribal representatives and IHS staff to meet managerial and technical demands for comprehensive health and medical services (DWTC), and
   3. the development of operational systems as a means of increasing the efficiency and effectiveness of health delivery systems (HPSC).

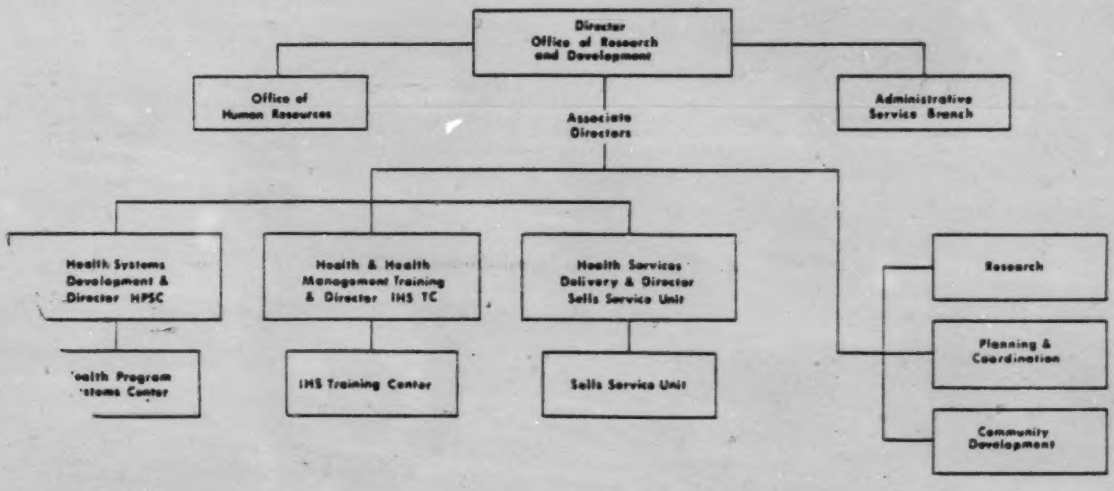
B. There are three other components, representing another dimension of ORD introduced for the express purpose of influencing the "attitudes"* of the preceding three functions:
   1. Research – a continuing review of ongoing research activities within the three components and the conceptualization and initial development of innovative alternatives to existing management methodologies.
   2. Community development concepts are constantly being introduced into operations and research activities. We are beginning to identify and analyze factors that have significant influence upon Indian management of their health (and all other) programs. Several efforts have been initiated to test ways of implementing this form of community development.
   3. **Planning and coordination** is a third point of emphasis. Emphasis is placed upon the integration and interaction of all resources of ORD to identify and achieve health objectives. A secondary role is that of coordinating Research, Development and Training achievements with the planning activities of IHS field activities.

* Attitude as used here refers to both psychological and physical, (as in aeronautics) definitions.

C **Interaction**

Within the formal organizational structure, Research and Development is an extension of the Office of the Director, IHS, with the responsibility for making its training, system development, and research capabilities and products available throughout the Indian Health Service. At the same time, however, the Office of Research and Development is directly engaged in providing medical and health services within the Sells Service Unit. This responsibility creates continuing working contacts with a Tribal governing body, Tribal health projects, and other State and Federal agencies.

The linkage indicated establishes a pattern whereby a full range of interactions can occur. New possibilities regularly are being discovered, tested, and utilized. For example, the Papago Tribal Government is developing experience in the utilization of ORD capabilities - and it is the kind of experience that will increase Tribal capabilities for fuller utilization of all available resources. It is this same linkage that results in an ORD staff member participating in an international symposium on hospital information systems - and making it possible for Indian hospitals to benefit from developments made in other parts of the world.



2. Health Programs Systems Center

As a constantly evolving operation there are many activities and programs being developed through OSRD, not all of which are limited to the Papago Reservation. However, most systems design and training programs are developed and pilot tested first with this population.

As a further example of this type of development, in 1973 OSRD began the development of STARPAHC (Space Technology Applied to Rural Papago Advanced Health Care). This involves a mobile van with medical equipment for treatment and transportation of the ill or injured. This van is linked to the IHS computer center, the Sells Service Unit, as well as to the Phoenix Indian Medical Center by microwave two way video and radio enabling prompt and effective diagnosis and treatment. This system utilizes Community Health Medics in addition to the usual range of IHS staff and becomes fully operational in 75-76, with planned evaluations and hopefully expansion not only to other IHS Areas but also to rural and isolated populations anywhere in the world.

a. General Relationships to IHS

Since OSRD is concerned with total health care, its activities are often tangential to or apparently independent of Mental Health Program considerations. Problems of developing a central patient record available to all outlying clinical service delivery points, inluding Public Health Nurses and Community Health Representatives with mobile telephone computer terminals in their cars has been one outstanding achievement of HPSC and the Sells Service Unit. Mental Health contacts are indexed, as are all other visits whether for routine immunizations or treatment of acute, traumatic or chronic health needs.

Care to protect confidentiality and to insure appropriate use of information has been a sub problem which appears to be solved to the satisfaction of field staff.

Mental Health needs also enter into the development of standards of care for specific diseases such as gastroenteritis among infants, and for diabetic or hypertensive patients. HPSC has developed protocols breaking these disease entities into stages of severity and corresponding immediate and long range treatment procedures. It has been informally observed that as severity and chronicity increase family disorganization and emotional stress which may arise from other sources often interact to complicate the utilization of medical services offered. Therefore consultation with or referral to Mental Health staff is being considered as part of the standards of care in these situations.

However, mental illness and emotional problems in general have not yielded to the systems analysis techniques which are proving effective for other disease entities. Primary focus of HPSC is on the 11-14 disease entities that can be shown from statistical analysis of the patient records to account for most of the demand for IHS services on the reservation. Those singled out so far have yielded to systems analysis, a series of teachable stages of severity and of treatment protocols which can be utlized by all levels of IHS personnel.

b. Specific Collaborative Work Between HPSC and Mental Health Programs

i. Alaska Alcoholism Project

As a part of the attempt to use systems theory tools in a mental health related field OSRD, under the general direction of Lawrence Berg, has been working with the Alaska Native Health Board

to develop standards of care in alcoholism treatment. One aspect of this effort is testing criteria for utilizing alternative treatment programs. This project is described in more detail in the report on the Alaska Area Mental Health Programs.

ii. Collaboration with Mental Health/Social Services Data Committee

In a general effort to develop a data base for planning and evaluation, as well as to provide a more adequate patient record system, the Mental Health and Social Services Branches of IHS have introduced a problem oriented record which can be entered into the IHS computer record system at Albuquerque. The staff of HPSC, particularly Charles McCarthey, has met with the joint Mental Health/ Social Services Committee throughout the three year period of introducing this record system and its first revisions after preliminary evaluation. This technical assistance as well as the exchange of information between OSRD and Mental Health and Social Services programs has resulted in the refinement and more efficient utlization of this instrument.

C. Desert Willow Training Center

The teaching arm of OSRD is the Desert Willow Training Center. It is most succinctly described in the OSRD Bulletin cited earlier :

> The Indian Health Service-Desert Willow Training Center in Tucson was established in 1968 as a training and resource aid to the Indian people and the Indian Health Service staff to:
> 1. Provide and increase technical competency in health;
> 2. to aid in the transition of program decision-making and operation from health professionals to the Indian people;
> 3. to develop and provide training courses, technical guidelines and field services to achieve 1 and 2.

The Desert Willow Training Center, operated by the Indian Health Service, is located on the grounds of a former dude-guest ranch, cradled in the living desert valley, surrounded by the rugged Santa Catalina, Rincon, Tanque Verde and Tucson Mountains. The area is enhanced by the ever interesting and changing desert flora and fauna.

The training facility, located on the eastern side of metropolitan Tucson, is within easy driving distance of many historical, archeological, geological and international points of interest. The facilities of the Center have been adapted to meet training needs.

The Center serves as a resource and training facility for the Indian Health Service, Public Health Service and the various Indian tribes.

Tucson, Arizona is a very suitable location for the Indian Health Service Training Center because its year around weather conditions provide the optimum climate for a total training environment. The close proximity of a number of Indian tribes and reservations allows for unique cross-cultural exchanges and field training experiences.

Services:

The Desert Willow Training Center is engaged in the provision of four (4) related types of services and training:

1. Technical and community development training
2. Audio-visual services
3. Field and health facilities services
4. Facility and logistical assistance and support to other training.

Among the training programs developed at Desert Willow Training Center are the cycles held several times yearly for Community Health Representatives, a two year program for Community Health Medics, Special Courses of varying lengths for Management training or designed to meet needs of staff in the field, and a program for training Mental Health Technicians.

The Mental Health Technician Course is described in outline as follows: (ORSD Indian Health Services Bulletin, p17)

The need for trained community workers in mental health has been apparent to the Indian Health Service for quite some time.

The first group of Indian Mental Health Technicians started training at the Indian Health Service Desert Willow Training Center, Tucson, Arizona, in May, 1971. The trainees in this first group were members of various tribes located in Arizona and Nevada.

Role of Mental Health Technicians:

As mental health specialists, they like the non-Indian professionals, work along side other health specialists to provide for the comprehensive health needs of the community. They help other health personnel understand the way people view their needs so that services and needs are most effectively complemented. He must be familiar with the Indian language. He must understand relationships and interrelationships of more than one culture and be able to translate each way.

MHT Training Program:

The Mental Health Technician training program is designed to train Mental Health Technicians who are generalists, yet flexible enough to shape their role or alter their activities to meet the demands of their work situations and the variable needs of the community in which they serve.

Correlating academic instruction, professional skills formations and on-the-job experiences so that they relate to the trainee.

Aid the trainee in envisioning the scope of his field - the learning and unlearning necessary -- the tasks ahead.

Skills Necessary:

Interviewing normal and disabled persons
Interpersonal relationships
Observing and recording
Reading and reporting
First aid and first-level physical diagnosis
Counseling

The training is a combination of classroom study, work experience under a preceptor and continuing education at a field location.

Purpose of Training:

The purpose of the MHT training is to prepare them to deal directly with major emotional problems of individuals, and to develop partnership programs with communities and other workers in related health fields.

Summary:

The Indian Mental Health Technician is employed by both Tribal and non-Tribal agencies. He has a career potential in the professions as well as the community. He has an opportunity to work with and assist juveniles, young adults and older people in the areas of misuse of alcohol and drugs, glue sniffing and others, school dripouts, ill-prepared marriages as well as cultural and daily life problems in general.

In 1973 Jerry Meketon, Ph.D., who has had charge of the MHT programs, Nadine Rund a training consultant and Marjorie Myren, Phoenix Area Chief of Mental Health Programs presented a description of the program after its first full year of implementation:

MENTAL HEALTH TECHNICIAN TRAINING AND THE AMERICAN INDIAN[1]

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Indian Health Service Training Center
Tucson, Arizona

Nadine H. Rund
Training Consultant
Management Training & Field Assistance
Indian Health Service Training Center
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Marjorie E. Myren
Chief, Area Mental Health Branch
Phoenix Area Indian Health Service
Phoenix, Arizona

[1] Portions of this article were read or discussed at the Seventh Annual Joint Meeting of the U.S. Public Health Service Commissioned Officers Association and Clinical Society, NYC, May, 1972 and the American Orthopsychiatric Association Annual Meeting, Detroit, April, 1972.

The need for trained community workers in mental health has become increasingly apparent to the Indian Health Service. The communicable and chronic diseases which occupied health staff so greatly for the past 15 years are being brought under control. Facilities have been built and expanded. Water, waste and housing systems are being completed in an increasing number of communities. As communicable and chronic diseases are reduced, the comparative importance of accidents, suicides, alcoholism and other social and mental health problems increases. These are health problems which cannot be solved solely by outside input. The community and individuals must be actively involved in uncovering solutions and carrying out programs.

Role of Mental Health Technician

Although there is considerable role variation among mental health workers throughout the nation, Indian Mental Health Technicians regardless of where they work have at least this much in common: They must walk carefully in two or more cultures without being captured exclusively by any. As mental health specialists, they are as non-Indian professionals, working alongside other health specialists to provide for the comprehensive health needs of the community. As community members or ones who have a special understanding of and relationship with the community, they help other health personnel understand the way the people view their needs so that services and needs are most effectively complemented.

Such cross-cultural mental health work is most difficult. The skills and knowledge demanded of the worker from non-Indian professionals and Indian communities are immense indeed. For example, the worker must be familiar with the native language. Without such

knowledge, his comprehension of the subtleties of the culture would be blunted and he would be essentially cut off from many of his clients (See, Jewell, 1952 for what ignornace of a language cost a Navaho). The Indian worker must understand relationships and inter-relationships of more than one culture and be prepared to translate them back and forth. He cannot assume that the Indian community and the hospital staff share the same concepts of health and illness, or individual responsibility for cause and cure of illness, or attitudes toward the patient-practitioner relationship and distinctions between mental and physical health. Finally, the Indian worker must be cautious that he does not fall into the common trap of community programs. The person who has been an effective unofficial community worker is given official recognition and training, but in the process loses the very acceptability that made him so effective. In the community's eyes, he may become a captive of an alien culture -- and outsider -- or worse an Indian replacement for an ineffectual Anglo position.

Perhaps one more point should be made that Reiff and Riessman (1964) give special emphasis. If we were only concerned with filling the gaps left by shortages in professional manpower, then it would make little difference whether or not the health worker was drawn from the same community he is to serve. Anyone with similar training could do the job. But if our intention is to reach people who have not been served before, or served ineffectively because of language or social differences, then the community based health worker is a necessity. Regardless of how difficult or tenuous his position may be, he cannot be replaced.

On Indian reservations, the Community Health Representative (CHR) is probably the definitive example of the indigenous health worker. He must be of the people; he is politically selected and tribally employed; his influence is based upon being among the first to know his people's needs and providing them with direct assistance for a wide range of social problems; and his career opportunities are community based, not professionally determined. It is easy to understand why tribal leaders often see the CHRs as rivals, since their methods of reaching people are similar (for a non-Indian example of an analogous situation, see Levine & Levine, 1970, Ch. 5). On the other hand, CHRs are often in the best position to gain the support of tribal leaders to fight for and obtain improvements in health care.

The Indian Mental Health Technician, however, occupies the middle ground between the CHR and the professional health worker. He is employed by both tribal and non-tribal agencies; he has career potential in the professions as well as the community; and though he may not have either the influence to effect social change as the CHR indigenous worker nor the credentials of the traditionally trained health professional, neither is he locked into the demands of their roles. In short, he is in an ideal position to bring together the strengths of both groups -- or be crushed by them.

Sundry Problems

Cultural Clash and Transition:

Until the Europeans arrived (bringing with them cholera, plague, small pox), the medicine man was quite capable of handling the illnesses of his people (Levy, 1972). Changes were inevitable, however,

and most Tribal and large urban cultures are breaking down or rapidly changing. Both Indian and non-Indian mental health practices are in trouble. How can we save and utilize what is helpful in both systems?

Para-professional Status:

Although para-professionals were first considered chiefly as an expedient resource in providing custodial care for the mentally ill or charity for the poor, now they are carrying out other roles for themselves, roles that some believe they can fulfull better than professionals because of their special characteristics and attributes (Sobey, 1970). Still, there is resistence to the "new careers" concept from many quarters and it is common to find para-professionals stuck in dead-end jobs.

Similarities and Differences:

There is no one Indian people, but a wide variety of tribes with different customs, problems and needs. Opinions are expressed, both Indian and non-Indian about local circumstances being so unique that only local inservice training is called for or acceptable. Furthermore, a variety of expectations concerning the role of the Mental Health Technician exist within the different tribal areas, as seen by the trainee, his employer, his community. How can we separate the training that is useable and relevant to all, from training that could be or should be given at the local level?

Credentials:

Despite some movement toward change, academic credentials are still needed in many places, simply to get a job -- not necessarily to perform it. Such emphasis on formal credits tends to exaggerate

manpower shortages and bar persons (often from minority groups) from even considering a professional career (DHEW, 1971). Yet a mission of the Indian Health Service is to help American Indians gain access to the professions. Training, therefor should be transferable to academic credits if this goal is to be met.

Reservation Life:

Perhaps more so than other groups in the United States, the American Indian is very attached to the land of his people, his tribe. Those who leave the reservation frequently return. And those who stay and occupy an influential position among the people (persons most sought after for mental health work) find it most difficult to leave the reservation for prolonged periods of time. They may be bright and academically prepared for college, but family obligations, kinship ties and community responsibilities are so great that they could not move away for two to four years without losing their ties and place in their community. For the most part, extended training would have to be brought to them.

The Development of a Profession:

"All health professions were established first on a preceptor basis, then over a period of years were developed in separate schools and hospitals and finally incorporated into college and university education (Matarazzo, 1971)." The practitioner-apprentice relationship is a powerful educational tool. But which practitioner to choose and how long an apprenticeship?

Beginnings of a Program

Planning sessions began in February, 1971 and an arrangement was worked out between the Phoenix Area (one of nine Indian Health Service Areas) and Desert Willow Training Center in Tucson, Arizona to develop training for Mental Health Technicians. Within four months, three conferences were held and six trainees were launched on a concentrated program of training. We tried to give the trainee as varied a curriculum as possible so they could help us set the structure for the program. In July, Central Arizona College joined us in our efforts and by October, 1971, the first semester started, bringing in together the resources of academic, professional health workers and tribal representatives. The class then contained ten trainees.

Over a one year period we introduced the students to instructors who worked in health services representing 16 different disciplines, from pediatrics to applied anthropology, psychiatry to Indian medicine. Trainees attended the American Orthopsychiatric Association Convention and conducted workshops for mental health professionals. Tribal Health Board Representatives were introduced to mental health concepts by the trainees and their consultants through a three day training program. In addition, the trainees were completing course work in Psychology (general, abnormal, developmental); Sociology (social problems, the community); Anthropology (cultural), English and Social Sciences, plus learning skills from their preceptor-supervisors and carrying out projects in their communities. Currently, nine trainees have finished their first year, eight the first semester, nine most recently admitted, and most have taken a summer session in residence at Central Arizona

College. These trainees come from six states and 13 different tribes.[2]

Current Program

As a result of the pooled experience of students, preceptors and instructors gathered during the past year, we are taking a new approach to the program which we hope will accomplish several things:

a) Turn out Mental Health Technicians who are generalists, but flexible enough to shape their role or alter their activities to meet the demands of their work situations and the variable needs of the community they serve.

b) Blending academic instruction, professional skills formations and experiences encountered on the job in such a way that they make sense to the trainee.

c) Helping the trainee to envision the scope of his field -- how much there is to learn and unlearn; how much needs to be done.

Expectations of the Developing Mental Health Technician:

Building on the guidelines suggested by the Southern Regional Education Board (DHEW, 1971), we have all agreed to work toward the following objectives for Mental Health Technicians:

Attitudes and Values

1. Awareness of one's own limitations and willingness to seek help. If there are difficulties in intra or interpersonal relationships, on or off the job, is the trainee seeking help in understanding and correcting these difficulties?

[2] Arizona, California, Montana, Nevada, New Mexico and Utah. Apache, Cherokee, Cocopah, Crow, Hopi, Hualapai, Miwok, Navajo, Paiute, Papago, Pima, Pueblo and Ute.

2. Conviction that organizations, agencies and social policies should be open to change to better meet client and community needs. Does the trainee show an interest in analysing the possible reasons for an agencies' ineffectiveness or does he settle for pat answers and scapegoat solutions?

3. Conviction that knowledge, skills and attitudes are in continuous change and that commitment to continuing self-development and education is necessary. Has the trainee recognizable long range vocational goals toward which he is working? Does the trainee ask meaningful questions provoked by reading or patient contacts?

4. Respect for the dignity of the individual--his person, privacy, decisions and opinions. Is the trainee condescending, patronizing or arbitrary in his relations with others--including both his clients and his supervisors?

5. Importance of exercising personal responsibility and initiative. Can the trainee be counted on to carry out assignments and share? Does he perform adequately within a system having time expectations? consistently? sporadically? Does the trainee use his superior knowledge of his culture for the benefit of clients and community?

Skills

1. Skills in interviewing normal and disabled persons:
   Talking with people comfortably and productively;
   Obtaining information, "reading" the feeling tones of what people say, and observing and reporting the behaviors people

exhibit in interviews;

Giving and interpreting information and appropriately responding to feeling tones and to the implications of what people say and do in interviews;

Relating to a wide range of the disabled--the aged, the mentally ill and retarded, children, alcoholics, etc.;

Sensing the impact of self on the person being interviewed, and responding appropriately.

2. Competence in interpersonal skills:

Establishing interpersonal relationships with clients either as individuals or in groups;

Dealing with other health workers in various role relationships;

Supervising others in a consulting relationship;

3. Skills in observing and recording:

Observing behaviors, emotions and physical characteristics of people and settings;

Using ordinary check forms to record observations;

Recording observation and interview data in simple descriptive fashion (this does not mean interpretive language, i.e., "patient is delusional" but in graphic descriptions of exactly what the person is saying and doing);

Recording subjective impressions of the individual.

4. Competence in reading and reporting skills:

Organizing information into logical and clear reports, both oral and written, including reports of clinical information, program development, problems or proposals.

5. Skill in first aid and first level physical diagnosis:
(This does not call for first aid in the full range of orthopedic situations, etc., or physical diagnosis comparable to that of a nurse. Rather it is that level of skill in first level diagnosis that would be expected of a rather sophisticated parent).

Recognizing the therapeutic, toxic, allergic and side effects of the most commonly used psychotropic drugs;
Recognizing and evaluating the signs and symptoms of generally common illnesses such as childhood diseases, heart attacks, as well as illnesses which may be uncommon for the general population, but frequent in their community. Basic skill in taking temperatures, pulses, and knowing the elementary significance of several commonly used clinical tests.
Making appropriate referrals or counseling clients and families when physical signs or symptoms present themselves. (This involves avoiding inappropriate and unnecessary referrals as would a sophisticated parent).

6. Skills in consultation:
Counseling with other workers about individuals and their problems (i.e., clarifying the problem and helping the consultee arrive at solutions);
Counseling with local agencies about their mental health problems.

Knowledge

1. Knowledge of the educational backgrounds, roles, functions and status considerations of the human service professionals:

The health professionals and their profession's power and influence. (Medicine, Health Educators, Sanitarians, Psychiatry, Psychology, Social Work and Nursing);
Health related professions, such as, rehabilitation counseling, occupational therapy, chaplaincy, recreation, physical therapy.
Middle-level mental health workers (psychiatric aides and attendents, alcohol counselors, CHRs, etc.)

2. Knowledge of personality theory and function. This would include:
Some knowledge of the most common concepts of normal personality growth and development from infancy to maturity and old age.
Some knowledge of the terminology and basic concepts of the more common theories of psychological functioning and especially knowledge of the kinds of situations for which the various theories seem especially useful.
Some knowledge of mental functions and their implications and applications.
Some knowledge of common personality patterns and behaviors (i.e., passivity, aggressiveness, dependence, independence, compulsiveness, mood swings, etc.). All of this should be aimed at recognition and understanding the meaning for counseling and managing persons with these patterns.

3. Knowledge of abnormal psychology:
Some knowledge of abnormal behaviors; descriptions, natural history and psychodynamic aspects of psychoses, neurosis, personality disorders, and psychophysiologic disorders.
Basic knowledge of psychopathologic conditions related to children, adolescents, and the aged as well as young and

middle-life adults.

Basic knowledge of the behaviors, natural history, and psychodynamics of special problems such as mental retardation, sex problems and alcohol and drug abuse.

4. Knowledge of the conceptual bases for various theories of intervention; knowing one system of treatment well.

Basic knowledge of the various models for individual client intervention (i.e., medical model, social learning model, etc.).
Basic knowledge of the principles of supportive treatment used for rehabilitating the physically and psychologically disabled.
Basic knowledge of the concepts of prevention, positive health promotion, social system intervention, anticipatory guidance, etc.

5. Knowledge of sociology and anthropology:

Basic knowledge of concepts of family and kinship systems.
Basic knowledge of concepts of special group behaviors and their implications for practice, e.g., institutions, communities, minority groups, public officials.
Basic knowledge of dynamics and processes of small and large groups and their uses.

Academic Links:

We decided from the very beginning that advancement as a Mental Health Technician would depend upon performance on the job, not academic credits. We believe that one would complement the other. However, academic advancement has other purposes--job mobility, preparation for other mental health professions and stimulation to "stretch the mind". In any case the trainee can leave the program

with credit, at several stages: Three weeks at DWTC = IHS Certificate; 1 year to IHS Testification and/or an Arizona Career Development Certificate in Mental Health Technology; 2 years (may be less depending upon prior training) for A.A. or A.S. degree in Mental Health Technology from Central Arizona College; transfer of credits possible to four year college or university.

The training program follows the academic calendar. Each semester is started with a three week stay at Desert Willow. The trainee is introduced to all of that semester's courses (though each three weeks at DWTC is a program in and by itself) which he continues out in the field under preceptor guidance and tutoral assistance. The following semester begins with four weeks at DWTC. The first week is set aside for trainees and instructors to review the previous semester's work, take examinations and counsel for weaknesses and strengths.

The preceptor-supervisor, among other things, is responsible for developing the practicums and directing the trainee's learning so that he is on course with local needs and demands. He also arranges for the trainee's field tutors and encourages the trainee's full participation in the program. Since a preceptor can be any mental health professional, the preceptor has the responsibility of introducing the trainee to other professionals in the field.

The trainee then, has the responsibility for understanding the culture and health practices of his own people. It would be presumptuous for us to teach him Indian medicine except in its broadest outlines. He must make his own local contacts, and reach his own conclusions on how best to proceed as a mental health practitioner. Together, over a period of time, all of us might share our experiences to cull the best from both worlds. But that is for the future.

During the summer, courses that cannot be efficiently taught in the field are handled at Central Arizona College or elsewhere. In addition, a two week clerkship in Mental Health Technology is reserved for the second year of training, to be held at the Arizona State Hospital under the guidance of the Mental Health Technology Department. Other training activities may be introduced for all trainees from time to time, depending upon resources and student's needs. And plans are currently underway for an eight week internship at Fort Logan Hospital, Denver, Colorado, upon completion of the associate degree.

Indian Health Service Civil Service Career Ladder for Mental Health Technicians (a rough overview):

GS. grade 3: entry trainee level; requires 1 year general experience.

GS. grade 4: advanced trainee level, but more complex assignments. Requires 1-1/2 years general experience + 1/2 year specific experience.

NOTE: For promotion in grade level on all of the following, MHT must be performing at the higher grade level according to supervisor's evaluation.

GS. grade 5: beyond trainee level; general guidance rather than detailed supervision. Requires 2 years general and 1 year specialized experience.

GS. grade 6: advanced performance level. Supervision minimal. Requires 2 years general, 2 years specialized experience and 1 year of training. Worker must demonstrate ability to help develop programs with Service Unit professionals.

GS. grades 7 & 8: proposed, but not operational. Worker must be fully independent. Develops, modifies and evaluates mental health programs.

Professional Developments

During the past few years, a proliferation of middle-level professional workers has arisen on the national scene. Role definition, intercommunication, educational and professional standards are all presenting problems for these workers. Despite the diversity of their services, be it educational, guidance, mental health, rehabilitation, corrections, they all deal directly with their clients and their personal response to their clients is often the major ingredient involved in helping produce desired changes. On this basis, the National Association of Human Services Technology (formerly the California Society of Psychiatric Techicians) has offered to gather these workers under one roof so that standards can be agreed upon roles clearly defined and public recognition accorded this new group of professionals.

This national association is also aware of the unique circumstances of American Indians living on reservations and is considering the possibility of chartering an Indian chapter that would cut across state lines, but have the same rights and privileges as state chapters.[3]

Such a move would bring us that much closer to learning from one another.*

[3]Personal conversation with Zoltan Fuzessery, Director of Research and Publication, N.A.H.S.T.

*Addendum November 6, 1972
The N.A.H.S.T. has agreed to admit an Indian Chapter

DESERT WILLOW TRAINING CENTER
Community Health Medic Program
Mental Health Training Unit

July 5-28, 1972

A G E N D A

Revised 7/3/72

WEDNESDAY, JULY 5

DWTC	9:00 - 12:00 p.m.	Orientation (Staff)
		Assignment of Special Projects
	1:00 - 4:00 p.m. Dr. Dan Levinson	Introduction to Clinical Syndromes Through Taped Interviews

THURSDAY, JULY 6

St. Mary's Hospital*	9:00 - 2:00 p.m.	Introduction to Hospital Staff
		Preparation for Applied Field Studies
Dr. Justice's Address	7:00 p.m.	Evening with Justice

*Ccordinator and Senior Preceptor for program at St. Mary's: Dr. Elliott Heiman

FRIDAY, JULY 7		
DWTC	8:30 - 10:30 a.m.	Meeting with Kansas group
	10:30 - 12:00 p.m.	Introduction to Concepts of Psychological Defense
	1:00 - 2:30 p.m.	Mental Status Review
	2:30 - 4:30 p.m. Al Flores	"A value system for Mental Health"
		Feedback
MONDAY, JULY 10		
DWTC	9:00 - 12:00 p.m. Dr. B. Kuhr	Interviewing (tape models)
	1:00 - 1:30 p.m.	Handling the Psychiatric Emergency
	1:30 - 4:30 p.m. Dr. J. Hill	Elements of Counseling
		Video Role Playing
		Feedback
TUESDAY, JULY 11		
St. Mary's Hospital*	9:00 a.m.	Case Work and Lecture
DWTC		Video Tapes — Incarcerated Narcotic Drug Abusers
		Feedback
WEDNESDAY, JULY 12		
DWTC	9:00 - 11:30 a.m. Detective Anaya	Illegally Abused Drugs
	1:00 - 2:30 p.m. Dr. Goldfein	Alcoholism
	2:30 - 4:30 p.m. Dr. P. Thut	Psychopharmacology

*Coordinator and Senior Preceptor for Program at St. Mary's: Dr. Elliot Heiman

THURSDAY, JULY 13		
St. Mary's Hospital*	9:00 a.m.	Case Work and Lecture
DWTC		Review
		Feedback
FRIDAY, JULY 14		
DWTC	9:00 - 12:00 p.m. Dr. Nadine Rund Dr. Dan Levinson	Concepts of Health and Illness
	1:00 - 2:30 p.m. Dr. Kerr	Lecture - "Problems of Sexuality"
	2:35 - 4:30 p.m. Al Flores	"A value system for Mental Health
		Feedback
MONDAY, JULY 17		
DWTC	9:00 - 11:30 Percy Pavatea, MHT Austin Titla, MHT	Concepts of Indian Medicine: Hopi Navajo Apache
	1:00 - 4:30 p.m. Mike Speshock, MSW	Social Case Work Interview
		Feedback
TUESDAY, JULY 18		
St. Mary's Hospital*	9:00 a.m.	Case Work and Lecture
		Review
		Feedback
WEDNESDAY, JULY 19		
DWTC	9:00 - 12:00 p.m. Dr. M. Levy	The Psychological Interview - Using Psychological Tests
	1:00 - 3:00 p.m.	Exam: On psychopathology and Interviewing

*Coordinator and Senior Preceptor for program at St. Mary's: Dr. Elliott Heiman

THURSDAY, JULY 20		
DWTC	Drs. Justice, Meketon and others will be discussants	Special Projects Presented and Discussed (written report due)
FRIDAY, JULY 21		
St. Mary's Hospital*	9:00 a.m.	Case Work and Lecture
MONDAY, JULY 24		
		Open for Student Requests
TUESDAY, JULY 25		
St. Mary's Hospital*	9:00 a.m.	Case Work, Review (written case presentation due)
		Case Presentations
WEDNESDAY, JULY 26		
Sells, Arizona	9:30 a.m. Cecil Williams, Sr., MHT Eugene Galvez, MHT	Papago Psychological Services - Sells
DWTC		Review
		Feedback

*Coordinator and Senior Preceptor for program at St. Mary's: Dr. Elliott Heiman

THURSDAY, JULY 27

St. Mary's Hospital*	9:00 a.m.	Case Work and Review
		Case Presentations

FRIDAY, JULY 28

DWTC	8:30 - 12:00 p.m.	Review
		Final Exam
		Final Feedback

*Coordinator and Senior Preceptor for Program at St. Mary's: Dr. Elliott Heiman

ADVISORS:

Drs. James W. Justice
Elliott Heiman
Daniel Levinson
Jerry Meketon

By late 1974 it became apparent that the first wave of critical need for training of Indian paraprofessionals in Mental Health had passed. In addition the Desert Willow Training Center staff became aware of a number of problems in the training itself, and especially in the application of that training and in the role definitions of Mental Health Technicians. These observations were summarized as follows by Dr. Meketon in the spring of 1975:

SUMMARY

Mental Health Technician Program
Desert Willow Training Center

Past, Present, Future

The Mental Health Technician program was founded in 1971 and designed to allow Indian Health Service trainees to take as little or as much training as they needed to fill their agency's requirements and their own career ambitions. A full complement of courses leading to the associate degree in Mental Health Technology was developed for Desert Willow Training Center and accredited through Central Arizona College.

During the first year and a half, only the Phoenix Area contracted for full participation in the program. Later, the Albuquerque Area sent their mental health workers, but the remaining Indian Health Service Areas, for a variety of reasons, had minimal participation. Consequently, in order to utilize the program's resources to the fullest, a broader range of trainees with different backgrounds and needs were admitted. Almost half the trainees were non-IHS employees at any given time after the second year of operation.

A variety of problems in scheduling, coordination, etc. developed, but in any case, we came to realize we were unrealistic in our original formulation of the program. For example:

1. When the curriculum is fixed, it is the characteristics of the trainees (their values and

experience), when they enter the program that primarily determine the outcome of the training experience (c.f. Axelrod et. al., 1969). Since we did not select the trainees, the curriculum had to be more variable and individualized.

2. Similarly, unless the students are fairly homogeneous in learning style and experience, it is unrealistic to expect them to learn in accordance with flow charts or boxes carrying the labels of particular courses and arranged in particular order. More commonly, trainees vary in mode and rate of learning and then only accept operationally what is personally meaningful and useful to them. Again, it was necessary to re-examine our teaching efforts--particularly the "back home" experience of the trainees.

3. Perhaps most important, the whole process of becoming a clinician--or human services worker--is far more a personal enterprise and far less a function of what a training program looks like on paper (c.f. Strupp, 1974). The trainee might learn particular techniques and theories, but if they do not fit with his cultural set, personal aspirations and work situation, the most significant aspects of the training enterprise are lost, both for the trainees and his agency. Consequently, we had to find better ways of bringing the work situation, the trainee's personal characteristics and the curriculum content closer together.

Program Re-orientation

By 1974, we had sufficient experience with different kinds of workshops, modularized courses, alternate, non-IHS training centers, instructional styles and varieties of trainees (CHRs, CHMs, mental health professionals), to put together a program proposal that capitalized on the skills common to all effective direct service workers (e.g., skills in listening, when and how to give advice, when and how to refer to others), but varied enough in content to satisfy field specialties, such as recreation leader, alcoholism counselor, mental health worker.

A two week "Introduction to Human Services" course was drafted and scheduled for November 1974 to see if the concept would work. However, the course had to be postponed until April 1975.

In the meantime, Arizona State laws governing tuition and college class procedures changed. Out of state students taking 7 credit hours or more would be charged $52.00 per credit hour up to a maximum of $625.00. Formerly there was no charge of any sort for accreditation. The Mental Health Technology program at Central Arizona College would be phased out during 1975. Although a new program, taking into account the changes, could be introduced at any time, no new students working toward a degree in Mental Health Technology could be admitted into the old program after the Spring session, 1974.

Activities of the Desert Willow Training Center mental health staff have also been changing

We have become more responsive to field requests for brief programs serving immediate field needs. We have worked more closely with specific agencies in the field. We are more closely identified with Community Health Representative and tribal employee training. These experiences have confirmed our belief in the plans we have projected for Fiscal Year 1976. Essentially, we plan to extend the Human Services Concept, expand our field services and move slowly in offering any elaborate, long range program (but preparing the groundwork for such a program if it is needed).

Status of Mental Health Technicians: Fiscal Year 1975

Between May, 1971 and May, 1974, 41 trainees entered the Mental Health Technician program. Some wanted just the basic three week course or a practicum or two, others a career certificate and still others, an asscciate degree and more. Some trainees did very well academically but not so well in personal growth and maturity. Others developed remarkable skills in working with people, but were not so successful in articulating theory. Most trainees developed themselves along several lines. But how successful has the program been in aiding trainees... "to function effectively in a variety of positions in social services, social development projects, rehabilitation agencies...?"

Qualifications:

Approximately 75% of the participants in the Mental Health Technician program are currently working in human services in or near

reservations. According to supervisors' ratings all are performing at the acceptable to exceptional levels. Four trainees have enrolled in or are enrolling in universities this year. Three lost their jobs--whereabouts unknown. One is a housewife, another on maternity leave and a third on extended sick leave. One is now deputy sheriff and a parttime mental health worker, and one is deceased.

All trainees have either initiated or aided in the development of new community projects. These projects ranged from the construction and implementation of recreation and human services centers to the development of volunteer programs for teenagers.

All trainees completed the basic three week course; 32 completed a minimum of one semester college equivalents; 24 completed a minimum of one year college equivalents and earned the career development certificate in Mental Health Technology; eight completed all requirements for the associate degree in Mental Health Technology and 11 more could complete the associate degree this year. All of this work was done while they were fully employed.

The Mental Health Technology program will have fulfilled all its commitments to trainees by the latter part of 1975. At this stage, the trainees primarily need guidance to select appropriate courses available elsewhere to complete their program. All the courses unique to the Mental Health Technology program, however, have been taken by or are currently being completed by trainees still actively involved with Desert Willow Training Center.

Human Service Movement at Large

Once it was recognized that the country's needs for mental health services were unlikely to be met by increasing the numbers of traditional mental health professionals (Albee, 1959), several experiments to increase the non-traditional mental health manpower pool were undertaken (c.f., Gartner & Riessman, 1971, 1974; Pattison & Elpers, 1972). For example:

1. Non-mental health professionals such as general physicians, nurses, ministers, were exhorted to expand their practice to include mental health problems. But these professionals already had enough work to do, liaison with mental health professionals did not develop and conservative forces among the mental health professionals stymied innovation. It was clear, though, that a variety of community agents had significant helping skills and could manage major mental health problems within the context of their roles.

2. The idea that people with natural abilities and broad life experience could learn to function as mental health counselors without extensive formal schooling prompted the recruitment of housewives to enlarge the manpower pool. Although these projects demonstrated that housewives with intensive inservice training were quite effective in the counselor role (Rioch, 1963), their lack of formal professional credentials prevented them from being utilized very widely (Grosser, Henry & Kelly, 1969).

3. The poverty programs of the 1960s which supported the creation of new jobs also stimulated experiments for testing the value of indigenous community mental health workers. The local recruit was expected to bridge the gap between his community's needs and conventional mental health services while he worked his way up a career ladder to professional status (Pearl & Reissman, 1965). This "new-careers" movement also hoped to change the roles of mental health professionals to form a more efficient bond with the clients they served.

Indeed, when the indigenous worker was given the chance, he did provide new services, had a broader, more effective contact with his community and given the training and backup, functioned fairly well in the primary care role (Neleigh, et. al, 1971). Unfortunately, career ladders rarely developed, the indigenous worker did not necessarily accept the liaison role. Sometimes he faught the mental health establishment and sometimes he identified with it forsaking his roots in the community. In part, the "new careers" did not develop because the "old careers" resisted change.

4. In the late 1950s, early 1960s, the crisis center movement (suicide prevention centers, free clinics, walk-in centers), began turning out another type or mental health worker. Trained volunteers appeared to render more effective treatment at times than the professionals,

Although volunteers and psychiatric aids have been utilized in hospitals for decades, their roles in the 1960s were expanded and taken more seriously.

5. Associate degree programs for mental health paraprofessionals started with an NIMH grant to Purdue University in 1965. Since then, more than 140 degree programs have been initiated throughout the country, all having as a major component of their curriculum, supervised clinical experience in community service programs (McPheeters, 1972).

Shortly after the Purdue program began, a few mental health institutions developed a career system alliance with community colleges. Psychiatric hospitals, for example, hired untrained personnel as full-time entry-level mental health workers, offered them academically credited inservice training and allotted them time to pursue the remaining courses needed to complete the associate degree. A variation of this method was adopted and modified by Desert Willow Training Center for Indian mental health technicians.

The associate degree programs appear to be achieving more success than the earlier manpower models. "There is modest, but widespread professional sanction for such workers... numerous civil-service career series that have been established reflect the growing bureaucratic sanction (Pattison & Elpers, 1972)."

6. Recent developments suggest a growing trend toward amalagmation of paraprofessionals to form a single group of Human Services Workers. "This human service movement appears to be budding in almost all of the 50 states and in most of the service fields--mental health, penology, public law, law enforcement, religion, education, and public affairs (Fisher, Mehr & Truckenbrod, 1974)."

Despite variations in titles, there is a growing recognition on the part of both paraprofessionals and employers that these workers share in common a core of skills and a philosophy of practice. The National Association of Human Services Technologies is one organization that capitalizes on these commonalities and accepts more than 40 different job titles as belonging to the Human Service Profession. Mental Health Technicians, Alcohol and Drug Abuse Counselors, Social Work Associates, Welfare Workers, among many others qualify for membership.

Implications

In view of the developments on the national scene and our experiences with the Mental Health Technician program over the past four years we believe the demand for training in human service skills will increase. Nor is there reason to suspect that the need for Mental Health Technicians at IHS installations

has decreased since last evaluated in 1973. However, it would be extremely difficult to reconstitute the Mental Health Technician program currently being phased out without IHS wide participation and commitment of trainee slots, and increasing the current budget at least fourfold. Even, then, this may not be the most efficient direction to take.

There are approximately 3,000 outreach workers in a variety of jobs on Indian reservations and the number is likely to increase. Although their tasks and roles might vary, there appears to be a foundation of activities basic to all such work. For example, they must have some conceptual basis for understanding their clients. They must have skills for communicating meaningfully with them. They must have skills for aiding clients to develop their own strengths. They must have means to work with complicated social systems--the same categories proposed by IHS administrators for mental health technicians.

Although spoken of quietly for some time, traditional mental health professionals now openly admit there is considerable overlap in both content of graduate training and professional practice among the different disciplines (Henry, Sims, & Spray, 1971). No one denies the need for the special services associated with the different professions nor the type of meticulous research and testing that can come from these emphases. But professionals have had great difficulty in sharing their common activities and the client has often been the one to suffer.

On the other hand, the majority of outreach workers or human services workers are not specialists in the sense they can focus on one aspect of a client's needs (Brill, 1974). By the very nature of the demands of their jobs, they are preventive and crisis oriented either helping clients to handle the overall demands of living or assisting them to utilize the specialized services of medical care, education, psychotherapy, etc.

Since training should be directly related to role performance; and since these workers' roles have much in common regardless of job title; and perhaps most important, they have not yet formed competitive guilds (as the professionals have done), why not train them together to work together?

Recommendations for Desert Willow Training Center:

1. Introduce a Human Service program to train small groups of field workers from the same locale to work as a team .

   If this two week program shows signs of success, repeat it two or three time during fiscal 76 and include two or three brief courses that will build upon the introductory course.

2. Increase field workshops, working with all categories of personnel at one time in one agency to help them clarify roles and relationships.

The Health Services Management program already performs this function. The Mental Health Technician program has been of some assistance. A greater collaborative effort is needed, however, to meet field demands and collect data for relevant curriculum development.

3. Continue to develop brief courses that reflect field needs and train field personnel to administer these courses. In most instances, this means updating and streamlining materials we already have on hand and teaching others to use them.

4. Work toward accreditation of training through current IHS paraprofessional personnel guidelines (GS 699-4/9), and academic and professional association recognition. Until we know whether a degree program in Human Services is feasible or desirable, let's attempt to articulate whatever courses are given with existing college programs. Where we cannot offer courses, let us offer accurate and appropriate guidance.

Addendum

In contrast to the dismal reports on Indian education for half of this century, Indian peoples have made enormous strides over the past few years. "There has been a rapid increase in the numbers of Indian college students during the decade from 1960 to 1970. Approximately 8,000 Indian students are now in

college. This constitutes about 12 percent of an age group that finish high school, 20 percent enter college, 10 percent enter another post high school institution, and 5 percent graduate from college with a four-year degree. These are relatively high proportions, compared with other American social groups with low family incomes (Havighurst, 1970)."

Furthermore, based upon self-report inventories and questionnaires sampling 30 different Indian communities, Indian youth turn out to be as well adjusted and have as high a self-esteem as their counter parts in the majority population. (c.f., Dreyer & Havighurst, 1970; Dreyer, 1970). One might question the research tools and the use of majority youth as a normative base (they are having serious problems too). Nevertheless, the trend is apparent--educated, sophisticated Indians are becoming increasingly available for service to their communities, for professional training, for opportunities in the county at large.

Still, we would be mistaken if we thought that training men and women is simply a matter of funding and organization. The process is a much more subtle and personal undertaking. The frustrations of college we might recall (if we haven't repressed them) are multiplied for the Indian student. Aside from the red-tape of application forms and mass registration; aside from the coldness of large institutions and unfamiliar routines; the Indian student must also adapt to campus values, dress, language and social life that are not simply strange or puzzling but may threaten his most deeply felt beliefs. Finally, unless one knows

how to "work the system", one can get lost in college. It would not be difficult to find many Indians who have had a year or more college credits without completing a single basic course to graduate.

There is no doubt that this rapid increase in Indian college students is in part attributable to an increase in available funds. But one must look elsewhere for the influences producing the modest increase in college graduates. One likely source are the organizations (such as the United Scholarship Service, Inc.), whose dedicated personnel help sustain the Indian student in school, lending him emotional support and acting as liaison with school and other institutions to ensure proper attention to individual and group educational needs.

If Indian Health Service training is to continue its involvement with academic credits we would be well advised to supply our trainees with guidance if they pursue a college degree. But we cannot do it on our own. We cannot afford to isolate ourselves from other organizations seeking to help the Indian student through the educational system. We should plan now to borrow the efforts of other organizations and lend our own strengths to fulfill a common objective--trained Indian men and women who can man and manage their own affairs.

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From this summary, and knowledge of Area training efforts, it is to be expected that Desert Willow Training Center will phase out training Mental Health Technicians. However, short workshops and special intensive courses developed in response to any Area's special request are still very much a part of the thinking of the Desert Willow Training Center staff.

Meanwhile, a fairly large component of mental health material is integrated into the CHR and CHM training programs. Audio visual materials have been and can continue to be developed by Desert Willow Training Center staff for use in Mental Health education and in-service training.

D. Papago Health System

1. The Bith Haa Model

It may seem to some paradoxical to change the focus of attention from Space Technology to Tribal Control of health programs. However, the Papago Executive Health System has been carefully developed by the tribe to preserve the distinctive qualities and values of Papago tradition. They are organized in such a fashion that the processes of program development and control are intimately related to the life styles and ways of thinking characteristic of this tribe.

The Papago Health System is in one sense parallel with the IHS Service Unit and in another is its extension or complementation arm.

It is comprehensive in its activities, and includes IHS services as only one part of its concerns. In order to better grasp its breadth and context the following material prepared in 1973 by the Papago Planning Department is quoted extensively.(From Descriptive Analysis of a Tribal Health System on Papago)

p. 167 blank

The History and Development of Health Systems and Health Programs on Papago

Papago Health System

Traditional medicine and Papago Health programs and their development.

The road to power is the killing of an eagle. The tale of the first dangerous eagle and of his subjugation by I'itoi (Earthmaker) has its place in the origin myth.

> A monster eagle lived in a mountain cave, where he took a woman to live with him and had a child. From the cave he flew down daily to the settlements and carried off the inhabitants for his food.
>
> I'itoi was appealed to. He promised to come in four days, but actually came in four years. Then he made various incomprehensible stipulations as to the weapons which were to be provided him. The people guessed his desire and gave him an obsidian knife and a number of sticks of hard wood. He drove the sticks into the rock cliff and mounted on them to the eagles' cave. There he turned himself into a fly and waited until the eagle was asleep. With the help of the woman, he cut off the head of the monster and of his child.
>
> After the victory, he placed the eagle feathers in a basket which is supposed to be kept by the inhabitants of Kaka. But he was sick from the power of the feathers and so taught the people the process of purification. He then promised that anyone who killed an eagle in the future should have power, but he must go through the same purification.

The Papago medicine man (ma'kai), is primarily a diviner and prophet. He "sees" the date of the first summer storm, the outcome of games, or the cause of disease. The function of the medicine man in his role dealing with diseases is primarily as a "seer" and diagnostician more than a healer.

This is because in the Papago area, there are diverse explanations of disease, each demanding its own form of cure and practitioner. The medicine man's "seeing" of one of these forms of disease has nothing to do with symptoms. These are ill defined at best, and any one of them might be attributed to any cause. Diagnosis is a purely introspective matter, in which the supernatural influence, which has sent disease, is revealed to the medicine man in a vision.

There are three supernatural causes of disease, all treated on the principle that like cures like. One is ceremonial lapse, which

meant some error or disrespect committed at a ceremony. Against such a breaking of taboo, the medicine man is powerless, and cure is in the hands of the ritualists who managed the performance. A second cause is the ill will of animals. Each of these controlled some particular disease, sent as punishment on human beings who has offended it. Again the medicine man is powerless unless he has dreamed of the animal in question. Only one kind of disease is usually treated by the medicine man himself. This is the kind caused by the intrusion of a foreign object in the patient's body, an explanation which is, perhaps, the most widely accepted of all. The object is thought to have been shot into place by sorcery, and therefore the medicine man, a potential sorcerer himself, is the proper person to remove it. His remedy is sucking and many of the medicine man-prophets add this to their specialties. Some diagnosticians, however, "do not have it in their dreams", and in that case them call in another medicine man. There are some medicine men who prescribe herbs diets, and steam baths, which cured. Some have the ability to set bones or perform operations. Treatment is done by singers who restore harmony by appropriate songs and/or rituals.

The medicine man is perhaps the only individualist in Papago society. He receives genuine pay for his services. He is not afraid of being rich, (in the way perceived by other Papagos as having more than his neighbors) nor does he have the stigma of being "stingy", which would blight another man. He pays for his eminence with the constant risk of his life.

The Papagos have always valued health and their lifestyle traditionally was geared to maintaining the health of the individual, family, and community. Critical to survival was "living in harmony with the environment". Medicine men were and continue today, to serve a primary role in preventing, diagnosing, maintaining, and in prescribing treatment of either the individual, family, or community.

Today medicine men still practice even though their number has diminished. Their role in a complex health system cannot be ignored for the Papago medicine man is powerful, respected, and feared by many of the people on the reservation, and they will continue to play a major role in community health.

When the Tribal health programs began, the medicine men were consulted and their advice followed. The Tribal health staff and all Tribal health programs in their development never forgets their presence and the Papago health system reflects this.

Prior to 1968 there were no Tribal health programs. The major source of health services was provided by Indian Health Service. In 1968 the Papago Tribe was approached by Indian Health Service and asked if they would like to participate in a new program called the Community Health Representative. This program gave to Tribes, in a contract form, monies to provide services. The first subcommittee on health was appointed by the Tribal Chairman in 1968 when the Tribe agreed to

initiate a CHR program. It was composed of six members from various sections of the reservation who worked closely with the Tribal Chairman and the Service Unit during the planning and training phases of the CHR program.

With the establishment of the CHR program, the subcommittee began to serve as a health board, with the Tribal Chairman serving as an ex-officio member. This board functioned from about 1968, through spring of 1971, as appointees of the Tribal Chairman. In spring of 1971, the chairman of the health board resigned and the board gradually became inactive.

The CHR program was to be the beginning of a Papago oriented health system. Villages, through their leaders, would be selecting the CHR's for their particular areas. A traditional decision making process was followed that would later be reflected in a health organization model rooted in a traditional form of government and decision making.

In April of 1971, the Papago Tribe found itself managing a growing number of programs made possible by Federal funding and tribal resources. The Chairman, at that time, became increasingly concerned with developing a tribal organization capable of managing these resources and being responsive to the needs of the people. He consequently initiated a number of actions, one of which was the appointment of an Ad Hoc committee to investigate alternative approaches to formation of a tribal health organization. Papago tribal staff members, IHS employees, and a consultant experienced in public health, were asked to and served on the Ad Hoc committee. The first meeting of the Ad Hoc committee was with the Tribal Chairman. At this meeting, the need to cluster programs around the functions of human development, physical and economic development and supporting services was discussed. It was felt that general policy formulation ie, Chairman and Council should be separated from operating policy formulation ie, Chairman and Tribal staff. Health was seen as a necessary program in human development. Shortly after the formation of this Ad Hoc committee, and after its first meeting with the Tribal Chairman, he was killed in an airplane crash. Several meetings were held and the Ad Hoc committee terminated in May, 1972, when its study was completed. (See "Report to The Papago Tribal Chairman of the Ad Hoc Committee for Papago Health Organization and Related Activities, May 15, 1972")

Between 1968 and 1971, the number and scope of tribally operated health programs grew. In the fall of 1971, there were six operating programs funded by various agencies. These programs were: Community Health Representative (CHR), Emergency Food and Medical Services (EFMS), Papago Nutrition Improvement Program (PNIP), Papago Psychological Services - usually called Mental Health (MH), Alcoholism Prevention Education Program, and Otitis Media - now the Disease Control Program (DC).

In the fall of 1971, following the second annual Tribal Health Workshop, the directors of these programs began to get together informally as a means of getting acquainted and exchanging information about their particular programs. As a result of these informal meetings, the directors readily saw the need for a closer working relationship, coordination, and planning. They began to meet once a month and elected a chairman and vice-chairman from their group. During this time, the group was not a formally recognized Tribal organization. At these sessions, the health directors began to raise various questions. A major question raised was one of organization. Questions such as: Should we organize? How do we organize? Shall we follow typical organization models? Can we organize and still include Papago tradition and culture? This last question was critical to stimulating the group to think in a direction that used their historical mind collectively and to develop an organizational model based on the traditional Papago decision making group process. This model is called the Bith Haa Model.

Several months after the death of the Tribal Chairman, the new chairman met with two of the health directors and delegated them to look into and carry out the necessary tasks in Tribal health.

By March of 1972, after a series of meetings with the other health directors, the group prepared to report to the Chairman and present him with the current status of the Tribal health programs. Size of staff, monies, activities, problems, and future projects. They had a preliminary plan for the coordination of these health activities and presented to him the idea of the EHS and the Bith Haa model.

In May of 1972, the Tribal Chairman, Vice-Chairman, other Tribal departments, Director of ORD, BIA Superintendent, Sells Service Unit Director, and Planning Department Director met with the health directors. At these meetings the same information which was given to the Tribal Chairman in March was discussed and the idea of the Bith Haa model and EHS presented.

Between March and July of 1972, several events began to take place which had to be presented to the Council. A major one was a telecommunication project. (To be discussed in detail later.) The health directors realizing the significance and need for total Tribal involvement, met with the Papago Council in June 1972, and informed them of some very preliminary discussions regarding a potential telecommunications project. This was a major task since it had to be discussed in the Papago language so that it could be understood in spite of its complexity and technicality. The health directors also presented a resume of all the Tribal health programs, activities, monies, staff size, to give them an appreciation of the scope of Tribal health, its future and the need for a coordinated, planning, and managing and policy making group.

The directors discussed the Bith Haa organizational model and the idea of an EHS. They prepared and presented a resolution which would authorize the EHS to act in behalf of the Tribe in all health matters. On July 7, 1972, resolution 43-72 was passed unanimously by the Papago Council. The Bith Haa and EHS were now formally recognized.

Shortly thereafter, some pilot project monies were contracted by IHS to the Tribe for "Coordination of Health Services". This contract provided money to begin staffing a central office with a secretary and facilitate carrying out some activities necessary for Tribal participation and coordination.

1. The Bith Haa model

How was the name Bith Haa given, and how did it come about? In early 1972, meeting with the Ad Hoc committee, two directors of the Tribal health programs began to describe how the directors were beginning to work as a group. During the discussion, it became apparent that they were simulating in a modified form, an organizational model known as the Porterfield model. As the similarities of their approach and the Porterfield were discussed, the health directors realized consciously or came to the conscious level of awareness, that they were fuctioning organizationally in a Papago tradition form. As this was illustrated to the Ad Hoc members, the Bith Haa model came to being, and became the symbolic form for graphically trying to describe what and how the Tribal health programs were trying to develop.

The following is an attempt to describe the Bith Haa model and the Bith Haa process. What does Bith Haa mean? Bith Haa translated from Papago means clay pot. The use of clay is very intrinsic to the symbolism for clay represents man and earth. Man, like other living things, comes from earth and returns to earth, its mother. Man is one with earth, and formed from earth. This is why the clay, "Bith" is so very critical. Clay is earth, earth is the mother who gives life to man; man comes from and returns to earth. Earth nourishes and supports life and is part of the continual process of creation.

The Bith Haa is based on very deep philosophical and spiritual roots — mother earth, man and his relationship to earth and man as a member of a more holistic environment and universe. The Bith Haa's origin reflects an Indian philosophical approach to life, and is expressed in the goal, as defined by the Executive Health Staff, of the Papago health system: "to live in harmony as O'Odham in the environment".

What function does the Bith Haa serve? A Bith Haa is a clay pot used for cooking food. Its symbol was chosen by the health

directors to illustrate the dynamics of a group process -- a process similar to that traditionally used by villages to functionally define problems, and make the necessary decisions to carry out the activities essential in reaching a goal.

How does this process work in developing, operating, and coordinating health programs? Ideally, the Bith Haa allows all participants the fluidity and flexibility to merge in an appropriate manner when it is necessary to analyze problems, develop alternatives, and select those most appropriate to Papago.

A pot is a fragile vessel that can easily be cracked or broken, and this is always considered important to remember when speaking of the Bith Haa model. The form of the pot simply enables it to contain the ingredients. In the Bith Haa, who makes up the ingredients inside the pot? Usually the ingredients are health staff, but it is not exclusive to tribal health staff or health program directors. The ingredients, which generally refer to human resources, can at times be identified by programs such as CHR, Disease Control, but these labels used are for the convenience of identifying specifically funded programs. In the actual dynamics, program identification is used only when useful, but is always secondary to the concept of the group. The individuals forming the group come from various parts of the reservation bringing different skills and experiences to enrich the whole. The group merges in various forms at various times. A group can be pairs of clusters, but always forms for the purpose of action oriented decisions. Some of the decisions are not made until the appropriate time or group can be brought together. Other community resourses can become part of the Bith Haa. For example, Head Start most recently became a permanent addition to the Bith Haa. Others, either individuals or agencies may be part of the pot on an ad hoc basis. The Bith Haa can include professionally trained, technical resource people, traditional practitioners, community members, and other types of community workers such as community development workers. The major point is that usually the pot contains a combination of people with skills, ideas, and knowledge needed to resolve problems. The "ingredients" or mixture of human resourses, vary then, depending on the nature of the task or problem, its scope, and its complexity. The Bith Haa process is not intended to be exclusive. People go in and out of the pot as appropriate. The "ingredients" can only become nourishment or "food" when the "cooking" is properly done. The ingredients are the human resources and their ideas in the pot. The cooking is the dynamic process within the pot that enables the ideas and resources to become a reality. Food nourishes and promotes life and may vary depending on the need and on the ingredients.

The mouth of the pot represents the Executive Health staff, the official spokesman for Tribal health programs. At present, the Executive Health Staff is made up of health program directors, a representa-

tive from Head Start, one from the Community Action program. The Community Health Medic is an ad hoc, non-voting member of the EHS. This group is responsible to the Council of the Papago Tribe for managing and operating health programs and for making or recommending decisions to the Council on health or related matters.

The first puff of steam represents the Office of Health Affairs. This office is not filled by any one individual and is not a position. The health affairs office is a function to be implemented as necessary. Any member of the Bith Haa can be the spokesman and assumes the function of the health affairs office whenever appropriate. At times the function of the office may be served by one member of the Executive Health Staff. At other times, a team of two or more people may function in that office. The representatives and functions of that office varies with the situation. Although the Executive Health Staff does have a chairman and vice-chairman, their duties are primarily related to calling the group together, chairing meetings or being initial contacts for the group.

Here are some examples of how the health affairs office works. In the Diarrhea Control project, the primary spokesman is the Director of the Disease Control program. That person coordinates and speaks for the group in this particular activity. For the telecommunications project, four members were given the responsibility for working with all the agencies involved in the NASA project. These four members have been in the situation from the beginning and make recommendations for changes to NASA, Indian Health Services, and Lockheed. They regularly report back to the rest of the group, to the Tribal Chairman, or to the Council. These four members are the health affairs office in this situation. In presenting health issues to the Council, all of the Executive Health Staff function as spokesmen in the health affairs office. When the Tribe is asked to send representation to outside health groups, the health program directors either ask two of the directors or other health staff to represent the Executive Health Staff and Tribe. For example, the member representing the Tribe at the National Indian Health Board is the CHR director who was considered a natural selection since the CHR program is considered the godfather of the other Tribal health programs. Thus, one can readily see that there are no "Chiefs", only individuals whose leadership qualities and experiences surface for, and are used by, the group whenever the occasion demands and according to the specific role required.

The second puff represents the Chairman of the Papago Council. He acts in behalf of the Council and is the contact for the Executive Health Staff on a day to day basis. He is kept informed of health matters in a monthly briefing session held with the Executive Health Staff and the Vice-Chairman of the Tribe. A bi-monthly detailed narrative report is also distributed to the four executive officers of the Tribe. If a health matter comes up that needs to be discussed with the Chairman or Vice-Chairman, then the Executive Health Staff or their representatives get together with them.

The third puff represents the Papago Council who is over all Tribal programs and activities. It is the Council, the elected representatives of the people, who passed resolution 43-72 in July, 1972, giving the health program directors the authority to act in their behalf as an Executive Health Staff. (See appendix 1) The Executive Health Staff, who in turn represents Tribal health programs, then relate to the Council by meeting with them and calling special Council meetings on health to discuss and report in detail, health problems, programs and activities. Any Council member can request the Executive Health Staff to work on a specific situation. For example, one district requested the Executive Health Staff to investigate a sewer line problem involving Pima County. The special Council meetings on health, conducted in Papago involves the program directors and their staff members.

The program directors, acting as an Executive Health Staff, determines what decisions must be taken to the Council for action. When the telecommunications project was first brought to the attention of the Executive Health Staff, they immediately took it to the Council. The Council in turn asked the Executive Health Staff to investigate this further and report back. The Executive Health Staff reported back to the Council who then passed a resolution approveing the NASA project. Another example of how the Executive Health Staff works with the Council is the Nursing Home project. When a private non-profit corporation expressed an interest in financing, on a lease agreement basis, a nursing home facility, the Executive Health Staff, represented by the chairman of the Committee on Aging, went before the Council and explained the details as then known. The Council, at another meeting, passed a resolution which authorized the Chairman of the Council and the Executive Health Staff to enter into negotiations with this corporation. The Executive Health Staff, at the request of the Committee on Aging, added a staff member to work on the nursing home project and all other projects related to the elderly. They also hired a consultant firm who specializes in programs for the elderly. In the course of the negotiations, it became clear that this corporation did not have the financing needed and wanted the Tribe to be responsible with them on a bank loan. This corporation also did not seem to have experience in the planning of a nursing home facility. The corporation finally decided to terminate the negotiations the staff person hired to work specifically on this, reported back to the Council to explain why the negotiations were dropped. This particular project involved several agencies and individuals including Legal Services, a consultant specialist on the nursing home, people in the Bith Haa, the Planning department of the Tribe as well as the Executive Health Staff and representation from the Committee on Aging.

The logs under the Bith Haa represent fuel. The fuel can be provided by the agencies serving the Tribe as resources. Fuel can either be dollars to finance programs, or resources. The fuel has

to be enough to cook the food so that it is neither raw because of insufficient wood, nor burned because there was too much wood burning at one time.

The wood, the pot, the ingredients, and the puffs of steam, would have no meaning without the community, represented in the drawing by a bow, and without the match, representing community needs. The community is the bow that activates and ignites the match to start the fuel and get the process in the pot cooking. On the other hand, if the community had a match, but no fuel or ingredients to cook, some of the needs would remain unmet.

This, in essence, describes as fully as possible the Bith Haa, its model, evolution, and process up to June of 1973.

2. Contrasts between typical organizations and Bith Haa

From the foregoing it can be readily seen that the Bith Haa process differs in many respects from typical organization models. These differences are discussed below as an aid to future evaluations.

1. Typical - Assumes we have adequate knowledge to specify what is to be done, how it is to be done, and to direct the implementation.

   Bith Haa - Assumes we have adequate knowledge to start doing and that the organization must learn and develop implementation strategies as learning progresses. An example is found in the development of the Diarrhea Control Project. A plan was formed after the field health groups, in the thinking sessions on health identified the need for looking into this.

2. Typical - Assumes a major management objective is to put right things that are wrong. Change is often the result of error and is to be controlled.

   Bith Haa - Assumes that the organization must be continually self-correcting, that change is to be expected and channeled. These changes are not seen as "errors".

3. Typical - Assumes we know more than we are able to use. The problem is using what we already know.

   Bith Haa - Assumes that we may not know what is needed, that we must continue to learn. The problem is to avoid transmitting and using erroneous information.

4. Typical - Assumes we know what should be done. The problem is in doing it well.

   Bith Haa - Assumes we know how to do many things. The problem is to determine what is worth doing and most important to do, hence the "thinking sessions in health", where directors and health staff identified priorities, objectives, goals, and the concern with two-way staff communication.

5. Typical - Assumes that effective internal management will lead to effective external relations.

   Bith Haa - Assumes that attending to the external relations will lead to more effective internal arrangements. The cross-cutting projects have demonstrated this. The infant gastroenteritis program revealed one program's need for monitoring tools for supervision.

6. Typical - Assumes we know what is to be done and have sufficient prior knowledge to do it. Plans are formulated and fixed before action is undertaken.

Bith Haa - Assumes prior knowledge is assumed to be insufficient. Plans are tentative and action leads to replanning as a repetitive process.

7. Typical - Assumes that organizations are relatively unchangeable and that men come and go.

   Bith Haa - Assumes that men persist and that organizational structures and forms are changeable, several examples of this were discussed above.

8. Typical - Assumes that organizations are stable inherently and external events cause change.

   Bith Haa - Assumes that organizations are basically changeful and stabilize only as events warrant.

9. Typical - Assumes that change is produced by focusing on organizational components.

   Bith Haa - Assumes that change is produced by focusing on inter-dependencies between units, hence the emphasis on joint projects.

10. Typical - Assumes that having decided what is to be done an organization is institutionalized to do it.

    Bith Haa - Assumes that action is started and an organization is created to continue the action and stabilize, if and as it is warranted by the problem.

11. Typical - Assumes that the manager is the central authority and has sufficient information to make decisions and get them implemented. He does not have to be accountable to staff for decisions or reasons behind those decisions.

    Bith Haa - Assumes that the manager should bring together the skills needed to make good decisions and removes impediments to their implementation. As program managers they are directly accountable to staff.

12. Typical - Assumes that conflict is to be suppressed as evidence of misunderstanding.

    Bith Haa - Assumes that conflict represents the search for alternatives and is encouraged.

13. Typical - Assumes that problems are to be assigned to existing organizations.

    Bith Haa - Constructs organizations if warranted to solve problems. As in the case of the Diarrhea project where personnel from three programs were formed into temporary teams.

14. Typical - Assumes that men and organizational elements are inherently aggressive and competitive.

    Bith Haa - Assumes that men and organizations are cooperative and supportive.

15. Typical - Assumes that rewards in the form of cash, commendations from higher authority and hierarchical promotion motivates performance.

    Bith Haa - Assumes that increased motivation is not necessarily based on money. Achieving recognition in the form of recognition, confidence and respect by peers motivates appropriate performance.

16. Typical - Assumes that people are controlled by rewards and punishments with development opportunities for reward.

    Bith Haa - Assumes that people are to be provided developmental opportunities with reward and punishment a secondary consideration.

17. Typical - Assumes that access to information should be restricted to enhance competitive positions.

    Bith Haa - Assumes just the opposite, hence the emphasis on open continuous program project information exchange in many modes.

The above listing of elements and contrasts was adapted from one developed by Robert Biller, Professor, School of Public Administration, University of California, Berkeley, California.

2. Papago Psychological Services

In the Monograph quoted there follows a description and analysis of the various individual programs withint the Bith Haa including Community Health Representatives, Nutrition Program, Papago Disease Control Program, Diarrhea Education program, Alcoholism Prevention and Education, and Papago Psychological Services.

This last, the Papago Psychological Services, is referred to as Mental Health both in the schematic representation of the Bith Haa and among the tribal leaders. The description of this program is given on pages 38-40:

Papago Psychological Services

The Papago Psychology Service was established in November of 1969. The development of this clinic on our Indian Reservation came about as a result of several factors. The University of Arizona Psychology Department clinic was seeking a more relevant model for training and program development and so was responsive when approached by a representative of the Indian Health Service Psychiatric Team which had recently made a visit to the Papago Reservation. The request by IHS was a modest one; exploring the use of graduate students to do testing with Indian children. The Indian Health Service Representative was, however, quite responsive to the Tribe's suggestion of exploring a much broader involvement which was to assist in developing a comprehensive mental health program. The first year (1969) for the P.P.S. Clinic started out as a traveling clinic from the University of Arizona to the reservation on a one-half day per week basis to provide testing and some individual counseling service. Staffing consisted of advanced clinical psychology graduate students and faculty supervisors. The Clinic maintained an overall philosophy of respecting and working within Papago values and Papago culture. In 1970, the first Papago Mental Health worker was hired; that same year the Indian Oasis School asked for assistance in evaluating students for the purpose of developing a special education program.

It was felt that the basic model of the clinic was working well and the more that it became involved in the activities of the Tribe, the greater the possibilities of developing further services.

The pressure for more services and more personnel for handling the services grew. Referrences came from IHS, school, legal, and CHR programs.

In keeping with the community psychology approach, the clinic stressed the employment and training of indigenous Papagos as case finders, translators, relationship links, and agents to carry out recommendations of the clinic's professional staff. Papago mental health workers were very important in the plan. Training them and encouraging them to develop professional skills and to obtain a professional education became a major objective along with the provision of services. The clinic consulted with Papago medicine men on cases which involved traditional Papago beliefs. The medicine men were considered professional consultants and paid at a professional fee. For example, one female client developed symptoms of continued weeping and depression. When she did not respond to initial treatment, two healers were consulted. They agreed that the source of her problem was that she had not fulfilled her responsibility to dead relatives with appropriate ritual. When she performed her responsibilities her symptoms left her and she continues in good health.

It should be noted that the community mental health approach worked very well, in most respects, to the conditions on the reservation. First, language and cultural differences between the middle class caucasian, professional staff and the people on the reservation were minimized by

working through Papago mental health workers and Papago medicine men. Second, because the professional time on the reservation is limited, consulting with persons who deal directly with patients was much more practical.

The growth of the clinic staff has not been able to keep up with the need for services. The primary staff growth has been that of increasing the number of Papago mental health workers from the original one to a current total of five. A social worker and a secretary have been added since then. The problem is partially alleviated by load sharing with PHNs, CHRs, IHS Clinic staff and others as appropriate.

In 1972-73, the Papago Psychology Service for the first full year was entirely under Tribal control and direction.

The staffing pattern includes the clinic's Director, a Deputy Director, three Papago mental health technicians, and one professional clinical psychologist who continues as the program's senior consultant on a two half-day a month basis. His services are primarily used for case review and consultation. The Indian Health Service liaison social worker with the clinic has been unable to continue in that role. Consequently, staff are making their own arrangements for consultation with IHS staff. Some services have been anticipated from Dr. Daniel Brown, Phoenix Area Office, although the details for this have not been, as yet, fully worked out.

The service continues to maintain its orientation as a total community consultation service facility. Direct services to Papagos with emotional problems still constitutes an important proportion of the clinic activities. In addition to attending regular hospital rounds, being available for consultation and referral, from Sells Hospital Unit, the clinic has established regular consultations and activities with a number of programs on the reservation. These include projects with the Baboquivari High School, Indian Oasis School, the Topawa School; occasional consultations are carried out at Santa Rosa Boarding School, and the San Xavier School.

The Psychology Service continues to consult with the Alcoholism Program. Other consulting activities with regard to developing a program for mental retarded, for the elderly, in consultation with law and order, the Tribal judge and other Tribal programs continue.

Some of the special projects indicated during this year included: Group therapy weekly with high school boys and girls continues along the model of the previous year's group. Last year a therapy group for junior high school girls was instituted and worked very successfully.

Monthly grand staff meetings continue. Every few months this grand staff is held in Tucson as a training meeting at the University of Arizona. The completion of an evaluation of the first year's group therapy program was very encouraging.

The summer mental health experience program for two Papago university students was continued by a grant from the Southern Arizona Mental Health Association. A grant at the same level of funding for this summer experience (1973) program was also awarded.

Participation continues in the training of mental health workers at Desert Willow and the attendance by several of the clinic's staff for training and as trainers.

Two-day-a-week mental health coverage in San Xavier District continues. The program coordinates with mental health agencies in the South Tucson area. Several Papagos have been hospitalized in Tucson during the year through our services.

The staff participated in several conferences concerning funding and record keeping which were sponsored by the National Institute of Mental Health and the Arizona State Department of Health. The service has affiliated with the Mental Health Clinics Organization of Arizona. Various members of the clinic's staff participated in the Western Psychological Association meetings, both in terms of reporting the results of the group therapy evaluation program and in a symposium on activities of mental health workers. Three members of the staff also were involved with the American Psychological Association, held in Montreal, Canada, and presented an over-all view of our mental health clinic and its operations.

Just recently four members of our staff attended a meeting of the American Association of Family Counseling in Palm Springs, California, and our presentation was on Papago marriage and family counseling.

A graduate student in clinical psychology is presently helping out on a two one-half day per month basis as an instrument in setting up group therapy and will gradually phase out as the mental health technicians develop to the point where they can carry on the therapy groups.

Dr. James Shore has been the Papago Psychology Service outside advisor during this past year. However, it is uncertain that he will continue in that role.

As the individual caseload and the number of group therapy projects increase, the clinic is increasingly hard pressed to adequately cover all needs which emphasizes not only the need for increased staff, but increased skills in load sharing.

3. Alcoholism Prevention and Education

Since the problems of Alcoholism are closely identified with mental health in nearly any thinking about community programs, the description of the Alcoholism Prevention and Education program is also quoted here from pages 44-46:

Alcoholism Prevention and Education Program

Alcoholism and severe problem drinking are substantial problems among the Papago people.

Prior to 1969 there was little or no recognition of the problem by tribal or governmental agencies. However, in June of 1969 a sub-committee of the Tribal Health Borad was established to investigate the alcoholism problem. Investigation substantiated that alcoholism was a serious problem and a funding proposal was prepared and submitted to OEO, HEW, and IHS. The original proposal was for three years of funds at an average cost of $62,000 per year. Some recent statistics are:

--July 1, 1972 - June 30, 1973: 70 arrests for Driving While Intoxicated were made on the reservation, 1,379 males and 143 females were arrested for Public Intoxication.

Approximately 80% of all traffic accidents on the reservation were alcohol related. Seventy percent of the cases handled by the Tribal judge involved domestic problems resulting from alcohol abuse. Ninety-eight children were abandoned and placed in custody - these were directly attributable to drinking in the home.

--Total caseload of the alcoholism program is about 300 clients: Of this, 95% are male between the ages of 25-3[illegible] years old. There is a potential caseload of 1,200 if services were to be expanded.

Principal emphasis was on an education and counseling program.

Initial funds were promised from OEO in December of 1970, but were not available until May of 1971. Fortunately, assistance from the Tribal Mental Health Program permitted hiring of the first two counselors in December 1970. Training for these counselors began in November of 1970 at the Southwestern Regional Indian Alcoholism Training Center of the University of Utah operating under an OEO grant.

The remaining three counselors were hired in April of 1971 and were also entered in the Counselors Training Course at the University of Utah. All five counselors are still with the program. Of the five counselors, one counselor has been promoted to Director of the Alcoholism Program. One other counselor has been promoted to Supervisor/Counselor. There also have been five new staff members hired. They are two counselors, one female and the only woman counselor on the staff, one secretary, one Halfway House Manager and one Assistant Manager, Halfway House. This brings a total of 10 staff members presently working in the Alcoholism Program.

In the beginning, the Alcoholism Program started having Alcoholism Education Meetings in eight villages on the reservation. There now are weekly meetings in thirteen villages with an average attendance of thirty to forty people per meeting. These Alcoholism Education Meetings were set up to inform the people of alcoholism and make them more aware of the problems of alcoholism, its warnings signs, symptoms, and the effects of alcoholism. At present, the program has set up Alcoholism Education Meetings in approximately thirteen villages, two boarding schools and one day school.

In the near future, the program is planning to go into more public schools and more boarding schools on and off the reservations. This is a result of having more attendance of youth at our Alcoholism Education Meetings. They are very much interested in our program and would like us to come and talk to them about our program.

The Alcoholism Program receives referrals from the hospital, Law and Order, TWEP, CHRs and Mental Health. They also get self referrals. The referrals are, for instance, referred as a single person, as a husband and wife or as a family. From January 1972 to December 1973, there were twelve walk-ins. This type of self referral is expected to increase. Treatment for these referrals is done with support ranging from the IHS Health Medical staff to the traditional practitioner. There are approximately 35 clients to each counselor.

The Alcoholism Program coordinates and communicates with outside agencies and is utilizing some of the following agencies. The Sacaton Halfway House, 23rd St. Halfway House, Maverick Halfway House and the Tucson Reception Center. This relies upon the individual's interest and a person can stay as long as he prefers in the Halfway House. Counseling is also provided. Individuals who prefer detoxifying are taken care of in Tucson at one of the agencies. The individual's preference for utilizing the services usually relies upon the family situation at home.

Problems of this program which are being worked on are:

(1) Counseling - very limited staff for magnitude of problem and the size of geographical area (3 million acres) and a widely dispersed population.

(2) Rehabilitation Services - no on-reservation facility like a halfway house. Planning is underway to develop such a facility at Sells. The facility will be a halfway house where persons can be referred for stablization, observation and treatment. The halfway house is being planned to serve approximately 20 day care clients and 12 intermediate long-term residents. The half way house will also assist in job training and/or placement and will work with the family and outreach workers toward full rehabilitation. This will facilitate coordination of activities and referrals from surrounding communities in particular, the Gila River Alcoholism Program and Sacaton Hospital (detoxification center) and penal systems in Pima, Pinal and Maricopa counties.

(3) Establishment of standards of care like those employed for the gastroenteritis project so that differing preventive and treatment programs can be evaluated.

(4) Improvement of documentation and analysis of data on clients and their families.

(5) Assess impact and quality of educational program activities so that it serves the purpose and so that it is continually oriented to Papago life styles.

(6) Continuing dialogue with traditional healers to gain the benefits of their insights with respect to causes of alcoholism.

One area in which the program hopes to expend more effort is in the area of schools. This is an area that has not been fully developed. At present, the counselors, due to insufficient time and staff have been meeting in an assembly with the elementary and junior high school students and have shown films. More in-dept contacts with students will be done as they are intergrally involved in the family setting.

From these programs the Papago Planning Department secured statements of objectives and goals, as it did for each of the other programs. These are given on page 56 of the report as follows:

Alcoholism

Goals: To provide a broad based program which will aid the people to deal with alcohol in an intelligent and controlled manner.

Objectives:

1. Identification of the alcoholic and other problem drinkers.
2. Identification of the causes of alcoholism.
3. Treatment and rehabilitation of the problem drinker.
4. Counseling and rehabilitation of the problem drinker.
5. Prevention of alcoholism and alcohol problems especially among the young people.

Mental Health

Goals: To provide mental health services to the Papago in a manner which respects Papago tradition and culture and reflects with the desire of the Papago people. To further the mental health clinic aims at training and developing Papagos in and for the mental health area to ultimately make the clinic a basically Papago staffed one.

Objectives:

1. Development of successful techniques for group therapy with high school boys.
2. Development of successful techniques for group therapy with high school girls.

3. Start actions to begin group sessions with mixed sex groups.
4. Obtain outside funds to support activities to acquaint several Papago university students with mental health interests while working directly with Papagos, and to attract them to training in the Mental Health field.
5. To make staff available as counselors to the activities at the teen center when it becomes operational.
6. Will work toward the development of a Sells based mental retardation program.

It can be seen that these two programs funded from different sources and staffed by personnel with complementary types of training, have much in common. Without the model of the Bith Haa which includes both in a comprehensive context with free exchange of information, rivalries and competition for scarce resources could easily arise. Here both are functioning without losing identities, in a coordinated fashion of potential mutual support.

4. Evaluation of the Bith Haa Model After Implementation

With these specific programs as illustrations of the levels of program development, it is easy to return to the total model and to ask how has this worked out? Are there difficulties in implementing a model based in very different thinking and using processes of administration and decision making that contrast so markedly with the usual American bureaucratic style?

These questions are at least partially answered in this same report in a frank discussion of problems encountered and how attempts were made to resolve them: (pages 57-64)

An Analysis of the Bith Haa Model and Process

Problems: While the Bith Haa model and process, and the Executive Health Staff are somewhat unique for health or other service organizations, they draw upon the traditional mechanisms of the Papago for organizing, planning, and decision making discussed earlier in this report. Nevertheless, the development of the Bith Haa has encountered problems with which the staffs continue to struggle. When the attempt to weld all programs into a common effort was initiated, the various Tribal health programs were functioning with few formal ties either among themselves, or the IHS Service Unit. They were conceived and established as independent, categorical projects. Although most had developed from needs identified by the CHR program, they had different funding sources and independent objectives. This initial mode of establishment was to be the basis for several of the problems. The problems encountered in the development of the Bith Haa model the first year were:

1. The Executive Health Staff dual role: As program Directors and as Executive Health Staff members.

2. The perceived threat (by individual program staffs) of an autocratic, centralized and remote power.

3. The difficulty of external agencies and other Tribal programs in adjusting to the idea of a group rather than an individual as decision maker.

4. The difficulties of implementing the traditional concept of leadership emerging, with the constraint and pressure of time and externally imposed deadlines often forcing issues.

5. Problems of communications and perception internally, externally, and across program boundaries.

Each of these problems and the method of coping with them will be discussed in turn.

1. Dual Role: Each member of the Executive Health Staff is also the program director of one of the tribal health programs discussed earlier. The meetings and joint activities of the Executive Health Staff were initially very time consuming and while this time requirement has diminished somewhat over the past year, time pressures remain great upon individuals who already hold full time positions. Since staffs of the programs possessed an incomplete understanding of the Bith Haa goals, objectives, and process, and to some extent, still do, and saw little benefit to them in exchange for less time from their program director, the EHS was resented and/or the absence of their "boss" or "leader" was resented. Staffs perceived this as a loss of time and atten-

tion that should be spent on them or the program. Interestingly, since most program staffs operate internally within the Bith Haa framework, they identified these negative feelings early and expressed what they felt was a serious problem to their directors. In discussing this, the directors felt that the problem in their dual roles lay partly with the need to develop their own staffs much more. That type of complex development could not happen overnight, and could not be imposed. The directors expressed a great deal of frustration during this phase. As managers and EHS, they were going through their own period of self development, and at the same time attempting to develop their staffs, delegating responsibilities so that the program work would continue when the director was not around to make decisions. Participation in the EHS would be impossible unless staff within the individual health programs are developing to function when the director is not there. It may take months or even years for a person to be developed to the point where they are unafraid to speak if for years they may not have issued an opinion about anything. Learning to think through various decisions or options as health staff was also part of their development. The directors realized how hard it is to attempt development of human resources in a multiplicity of areas, all crucial to keeping alive the Bith Haa process.

Another factor in the problem of the dual role, was that three of the five programs were very new and for some of the directors this was their first experience in the role of managers and for all the directors it was their first experience as Executive Health Staff. With new programs, the program director had many details to attend to as part of establishing and beginning to operate a full field program. In the role as EHS members, with the responsibility given them by the Papago Council, it was some time before they felt comfortable with the awesomeness of the emerging role and the responsibility in the area of total health development for the Tribe. It was like being immersed in whatever was happening in total Tribal health, responding to it, while trying to communicate problems and dialogue with the Tribe, administration, health staff, and various agencies.

Approaches to these problems varied. Two programs identified alternate leadership to handle things when the director was unavailable. One director sought to strengthen line supervision through formal and informal training. Another director, pulled away temporarily from active participation in the EHS while making changes in the staff of the program to permit it to operate with less detailed supervision. Another program director continued to function in the dual

role but stressed more detailed program staff reviews, of what the EHS was doing to help staff understand total program benefits and therefore help him to fulfill the requirements of the dual role. The EHS, as a total group in discussing possible solutions, tried various things. As part of developing staff they had very early, a "thinking session" on health. Directors and various members from the health programs met for two days and dialogued about tribal health goals, health problems, and health priorities. This brainstorming session produced a series of actions but perhaps the most crucial one was that the tribal health programs, as a group of Papagos and as a group of health workers, got together and defined for the Tribe their own health goals, needs, and priorities. The Bith Haa process and Bith Haa model was discussed so that its implications could be better understood and seen. The idea that health workers might be better able to work together in a team approach began to emerge. Infant Gastroenteritis and environmental health were identified then as major health problems and priorities, which eventually led to the development of a diarrhea control project. Another thing that the directors did was to restructure the Third Annual Health Workshop to make it more functional. This reservation wide health workshop held annually, was initially conducted for the purpose of informing the people about various health programs and explaning what they do. Health workshops also enabled the health staffs to hear from the people - get their reactions, perceptions, and expressions of health problems and needs. At the third workshop held in December 1972, each program had individual rooms where small groups of people could meet with each program staff - in a seminar-style setting, and ask questions, and get a deeper exposure to that program's activities. The Bith Haa model was explained for the first time to a large group composed of residents from all parts of the reservation and the officers of the EHS met individually with small groups of people and discussed the Bith Haa model.

The EHS also began to call special Tribal Council meetings on health to explain in detail to the Papago Council, the various issues on health that were coming up, to apprise them of the current status, and to get their opinions. Again, the directors and the programstaffs were involved in this as phases of joint development and responsiblility to the Papago Council. None of these approaches is considered final; they are all tentative and the dual role will continue to be an area of concern for directors and staff. The approaches and possible solutions are working with varying degrees of success. The success is dependent largely on the personal growth of the tribal health staff and in their

ability to identify areas of discontent early, dialogue about them, and be unafraid and open to try various approaches.

Unanimity exists on one point; by whatever mechanism, staff development for more appropriate independent operation and decision making is seen as a good for both practical and humanistic reasons. The responsibility for seeing that this happens is seen as the responsibility of the program director. Projects like infant gastroenteritis have served to facilitate this process by giving some project staffs experiences in working together across program or agency boundaries with marked success and have demonstrated practical benefits or some of the abstract principles of the Bith Haa.

2. The perceived threat by individual program staffs of an autocratic, centralized and remote power: While consensual decision making is a Papago tradition, most programs were internally organized along the typical chain of command model and up until late 1971, these programs had been operating independently. The program directors hardly knew one another and had little contact prior to the Fall of 1971. When the directors began to meet, the need for overall coordination and planning became critical. This led to the development of an organization plan and finally to the formal endorsement by the Papago Council of the EHS. This was discussed in Section III.

   As an EHS meeting weekly, they began to attend to the multitude of problems and issues needing their decisions. Agencies and individuals now having "a responsive group" that was formally recognized by the Council came to the EHS with problems or for advice, decisions or support. The EHS was barraged and almost overwhelmed by requests and activities all needing their attention. The pressures of being overall coordinators and policy makers were felt. At this same time, two agencies, NASA and University of Arizona, were presenting the EHS with a telecommunications project. A new Service Unit Director was hired and the diarrhea project was in its initial planning stages. In the meantime, individual programs had to be attended to, by their directors, new programs were emerging and the health staff soon realized that their directors were thrown into another role.

   The directors, now more visible as a group, were being perceived by some of the health workers as "those higher up". This perception is understandable as the EHS was not meeting with the Tribal Council and its executive officers, NASA officials, and agency officials like the Director of ORD, and BIA Superintendent. These associations were interpreted by some that the EHS would become removed from the

field worker and would begin to be bureaucratic. They feared that the EHS would be telling health staffs how to operate their programs and would begin interfering with internal programs, decisions, and autonomy.

The EHS did all it could to allay such fears and continued strongly supporting and advocating the efforts of individual programs while attempting to begin coordination of individual program efforts. How the director communicates with, relates to, and keeps his staff informed of the EHS activities is primary. This area of individual program autonomy and overall Tribal health efforts is one where a delicate balance must be maintained because of the increasing inter-dependency of various health programs and agency resources in the creation of a team effort and optional utilization and development of its human resources in health.

The objectives, methods, and behavior of the EHS has not supported the image of a "remote centralized authority". The fear of some of the staff is apparently dormant, however, not completely gone. Only constant proof by appropriate behavior over a period of time will put those fears to rest. This will only happen with the test of time; however the chances of the EHS becoming a centralized, autocratic group is almost impossible. The Tribal health staffs, the Bith Haa - organization model and process, and the group program directors would not allow it.

Several approaches to this particular problem were tried. These approaches and their relationship to the development of individual health staff have been discussed in the dual role.

The joint projects such as putting together an annual health workshop - developing joint training activities which involved all health programs conducting informal thinking sessions on health where staffs and directors developed health priorities, have helped staff to see the benefits of joint action. They have begun to recognize the desire of the EHS for input from all levels of staff, field workers, secretaries, field supervisors and others to problem definition and solution.

3. The group as a leader: While decisions by concensus is a Papago tradition, the traditional modes for decision making were not immediately seen as appropriate either internally or externally. Although most health directors solicited staff input for individual program objectives and operations, the recognition and acceptance of this process applied to overall Tribal health coordination within and across programs, has and is coming slowly. Perhaps part of this can be attributed to the newness of coordinated Tribal groups and

the conviction that the Bith Haa, a result of a Papago process personified by the EHS, could work "organizationally". Leadership on Papago is only earned over a long period of time. This leadership has to be put through the various tests by health staffs, reservation residents, district and Tribal councils before it will fully be accorded the recognition it deserves. These "tests of performance", an internal process have, and will continue to be difficult. The EHS has already had to defend or explain certain positions before the Council and has gone through various district meetings for the same purpose. Within the health programs, the directors have always been accountable to their staffs and encourage the open discussions of any discontent or misapprehension. Since the EHS has been formally recognized by the Tribal Council, it has supported various individual health program efforts. When the Disease Control program was having a problem with the Regional Medical Program and questioned a contract RMP had from IHS to provide technical assistance, the Chairman of the EHS, together with that program director and Tribal health advisor, met with the Director of ORD and administration from Regional Medical program and resolved the problem.

The Nutrition Program was having problems assuring future funding when the CDC demonstration grant was up. The EHS advocated for supplemental funding and approached IHS. Indian Health Service was able to fund part of the Nutrition program through the funding mechanism of five CHR specialist positions. The Alcoholism program found itself in a dilemma because of funding restrictions through their NIAAA grant. The EHS advocated for budget reallocation so that funds could be used more realistically. Because of the competence the EHS has shown, the Tribe has been able to negotiate more on its own terms so that monies and grants or contracts are negotiated to protect Tribal interests and so that some control can be maintained by the Tribe.

These are examples of how the EHS, by its behavior, is committed to an advocacy and supportive role to individual Tribal programs. Criticism will always be part of the job. Slowly, the feelings of fear and dissent are being replaced by confidence that this group will act in the best interest of the Tribe. The majority of the health staff and other Tribal employees support and respect the EHS. The mounting responsibilities placed on their shoulders is indicative of the recognition it has gained. Again, joint projects had facilitated this recognition as has discussion with individual program staffs.

Externally, most agencies have no concept of Papago culture and tradition. They are not accustomed to a group decision process, hence find decision making by the Bith Haa foreign and perhaps not real. From this perspective seeking the decision maker or boss is normal. Some attempts have been made to isolate one or more program directors to reverse decisions seen as unfavorable, but the group has coalesced around the individual and provided support. Locally, IHS and NASA STARPAHC managements seem to understand and are supportive of the EHS, both administratively and technically. However, the problem will continue with other agencies who deal with EHS on a more transitory and less intensive basis.

4. Emergence of Leadership: Open, aggressive competition for leadership positions is not favored by Papago tradition. Leaders emerge and are followed because of demonstrated competence. (Respect is conferred by peers after being earned. This process is implicit in the Bith Haa, but is highly stressed because of accelerated time, schedule demands not always compatible with time requirements for leadership development.) In the case of infant gastroenteritis, the program director most appropriate by training and skills emerged as leader, and not the project director who commanded the greatest number of staff involved in the project. For interface with IHS and NASA on STARPAHC, EHS selected those program directors most concerned with the technical and service issues raised by the project as well as an IHS Papago CHM. The recently initiated Area Health Team meetings will provide another vehicle for cross program leadership to emerge and will probably evolve additonal organizational forms to facilitate joint activities and decision making at a local level with EHS working more towards removing blockages to those decisions by marshalling inter-agency or tribal support of a technical, organizational or financial nature.

5. Communications: All of the problems discussed above could probably be at least partially subsumed under this one. The other problems all have communications aspects, however, the most critical communications at this time are those between EHS and program/project staffs. Two way communications with villages and districts are also perceived by EHS as in need of improvement, but with the size and distance it will take longer. Communications are not seen simply as the exchange of messages but a commonly agreed to and accepted concept of goals, objectives and methods. In Papago this concept is better described by analogy. Communication of real understanding is expressed as illumination - like rays of sun shedding light on all, illuminating full and even so that perceptions are clear, not distorted by shadows. Taken in this meaning,

the problem will probably never be completely solved. However, discussions with staff, joint projects and area health teams and planned district health fairs are solutions being attempted. The EHS has found, like programs in many other contexts, that fully informing program secretaries are a most helpful communication device. Given full information they can provide linkages for staff.

5. Concluding Comments

As Director of the Papago Psychological Services, Cecil Williams has been a member of the Executive Health Staff from the time of its formation. Together with his assistant, Director Gene Galvan and other staff, he has energetically developed funding sources, supervised students from nearby college programs, developed training materials for the Desert Willow Training Center's Mental Health Technician and Community Health Representative programs, as well as developing several forms of service delivery to the people whom they serve. IHS has contributed funds from its Headquarters budget and a liaison with the Phoenix Area Office is maintained even though this Mental Health program is not administered by IHS.

It has seemed appropriate to present this material in some detail because it is one of the few examples of successfully operated Tribal Mental Health Programs. While the Bith Haa model in detail is unique to this particular culture, similar processes and an openness to administrative models adapted to the tribal context are essentially replicable. It is not incongruous to hold in mind simultaneously the image of an ancient clay pot simmering over a fire and of a space satellite capable of broadcasting impulses to a computerized record system and video communication between isolated patient and the most modern specialist. As these images become realities the objectives of both IHS and the Papago Health System and those of other tribes can become actualized.

E. Summary of Mental Health Status in Tucson Sub-Area

1. Problems Yet to be Resolved

1. Concepts of Mental Health and Mental Illness are confounded at many levels of stress and with many perceptions of deviant behavior. There has not been sufficient clarity in role and task definition, nor in description of behavioral signs of distress and pathology to develop adequate systems analysis tools for Mental Health. This is true for the field as a whole, not just in IHS settings. This poses serious problems for integrating the Mental Health Programs into the Health Programs Systems Center system, and results in rather low priority being given to these factors in planning and in applying space age technology to problems of service delivery. HPSC has very little access to mental health personnel sophisticated in both cross cultural behaviors and Community Mental Health as well as systems concepts. This basic gap needs to be narrowed if Mental Health programs are to be integrated into total comprehensive Health delivery systems developed by the OSRD.

2. Desert Willow Training Center is too locally oriented, both in geographic distance and in its experiential base, to be able to function as a central IHS training facility for Mental Health Technicians. The Desert Willow Training Center program in this Area has served the Phoenix and Albuquerque Areas in their initial phases of paraprofessional development and finds even this roughly four state region (Arizona,

Nevada, New Mexico, and Southern Colorado) too vast for its staff to remain in close contact with local needs and too heterogeneous in its selection procedures for efficient training programs.

3. The Papago Psychological Service is presently viable, but its ability to depend on IHS resources other than those of OSRD is tenuous and unclear. Contributions from IHS of consultants, personnel and budget have no sure channels, and those presently available could disappear almost overnight with changes in personnel or IHS policy. To be explicit, should the Phoenix Area Office or Mental Health Program Headquarters budget for this program, in addition to the Tucson Sub-Area?

4. Similarly, the experience and model of the Bith Haa and the role of the Mental Health Program in the total context of the Papago Health System is not widely known throughout IHS. This is true in converse to some extent although the Papago staff have partial access to information from other Area programs. There has not been adequate exchange over time between this staff and program and others throughout IHS.

2. Accomplishments in Mental Health

1. A developing awareness of the role of emotional stress in the problem of delivering health services at all levels of severity. Particularly some evidence of awareness of the barriers social and emotional problems present in the ability of patients and their families to utilize health services. These perceptions are still at an informal, almost subliminal level but are becoming discussable among OSRD staff.

2. The accumulation of experience and the sharing of expertise in certain defined situations between OSRD staff and Area/Service Unit

Mental Health programs. This is particularly evident in the loan of OSRD staff to the MH/SS committee developing a computerized problem oriented record, and in the loan of staff to the Phoenix Mental Health Program Area Office.

3. The training at Desert Willow Training Center of all Mental Health Technicians for the Phoenix Area, most of those in the Albuquerque Area, and a number from other Areas and for positions outside of IHS.

4. Linkage of this in-service training with academic institutions so that trainees can earn recognized degrees.

5. Maintenance of a sufficiently flexible attitude at DWTC to be able to phase out the original MHT program and adopt to needs expressed for field courses and other training assistance.

6. The development of a viable tribal Mental Health program as part of a Comprehensive Health System for the Papago Reservation.